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RAISING THE STANDARDS OF PUBLIC TUBERCULOSIS SANATORIUMS IN ILLINOIS*

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THE conditions surrounding public tuberculosis sanatoriums in Illinois are such that the elevation of the standards of these institutions requires unusual treatment. Until a very few years ago, Illinois had done less than any of the major states of the Union toward providing sanatorium treatment for her tuberculous people. There has never been a state sanatorium and the state government has never gone so far as to create a commission for the study of the tuberculosis problem, or the creation of a board for the standardization or control of institutions. As late as 1917 there were practically no public sanatoriums in Illinois outside of Cook County and the Chicago District.

During 1917, however, the Illinois Tuberculosis Association entered into active campaigns in a large number of counties under the provisions of the very excellent county tuberculosis sanatorium law. The result of these campaigns was exceedingly gratifying. Within a period of four years, about one-half of the hundred and two

counties in the state had voted favorably on the proposition of establishing sanatoriums free to all persons, regardless of financial condition, and establishing free dispensaries and visiting nurse service.

What appeared to be a splendid victory for the state association soon threatened to become a distinct source of embarrassment. The county tuberculosis sanatorium boards in the various counties were, for the most part, made up of men and women who had not had the slightest experience in sanatorium construction, organization, or management, but, with the splendid enthusiasm created by the state association, many of the boards went boldly ahead making mistakes which threatened the future of the entire sanatorium program.

For the most part, the members of the sanatorium boards appeared to feel that the development of a sanatorium is a very simple matter, which can be safely entrusted to the local architect and contractor.

In Illinois, as in many other states, the chief relationship of the county government to medical matters, consists in the care and treatment of

*Presented before the American Sanatorium Association, New York, June 12, 1921.



An "Illinois type" sanatorium.

paupers and destitute persons; and it was found very difficult to impress upon the sanatorium boards that, under the provisions of the law, the Illinois county sanatorium has nothing more to do with the pauper or indigent person than has the public school system of the state.

On account of the unfortunate exaggeration of the infectiousness and contagiousness of tuberculosis, it was found that the sanatorium boards regarded the county tuberculosis institution as somewhat akin to the isolation hospital or pest house, this sentiment being manifested in the selection of unfavorable and isolated locations and the consideration of pest house types of buildings.

While the state department of public health has certain limited jurisdiction over county and municipal hospitals, its authority extends only to the



One of the three cottages on wheels in which the Pilgrims traveled.

point of inspecting and recommending changes or improvements, but there is no penalty imposed upon the sanatorium board for ignoring the recommendation of the state department of public health, nor has the department any specific power to dictate or direct methods of diagnosis, treatment, or institutional operation. Under its general powers, of course, the state department of public health can assume supervision of the tuberculosis sanatorium on the ground that it is a place for the isolation of persons suffering from communicable diseases; but this could not be successfully done unless the violation of precautionary measures were flagrant and the institutional management exceedingly bad. In other words, there is no constituted authority in the state of Illinois legally authorized to pass upon the standards of tuberculosis sanatoriums.

In view of the mistakes that had been made in the sanatoriums already established and in view of the large number of institutions to be established within the next few years, it became imperative that something be done and the state department of public health and the Illinois Tuberculosis Association undertook the inspection and rating of existing sanatoriums, utilizing the limited authority given to the department of health. By exercising the utmost tact and diplomacy in carrying out the program, but one

institution of the twelve in operation offered objection to the inspection; all of the others placing at the disposal of the inspectors every possible facility, and acting promptly on all recommendations made.

We were able to secure the services of Dr. W. H. Watterson, who is now connected with the United States Public Health Service, and who has had perhaps a more varied experience in the operation of sanatoriums, both large and small, public and private, than any other man in the Middle West. In making the inspection, Dr. Watterson employed the scheme of rating adopted by the American Sanatorium Association* with certain minor modifications deemed advisable in view of the provisions of the Illinois sanatorium law, and it was definitely understood that the first ratings would not be made public, but would be used for the guidance of the sanatorium boards in bringing about desirable changes and reforms. It was made clear to the sanatorium boards, however, that subsequent inspections would be made and that the results of all later ratings would be widely published for the guidance of the medical profession and the public.

The policy was pursued of allowing additional credit for exceptional features in institutional operation not ordinarily expected in sanatoriums of that particular size and type and the practice was followed, in rating all institutions, to give no credit for unused or misused equipment, but rather to place the accent upon the character of professional service.

Use of Equipment Counted

For example, an elaborate and expensive x-ray equipment entitled the institution to very little credit unless it was demonstrated that the methods of employment were technically correct and the medical staff capable of intelligent interpretation of their findings. The intelligent employment of artificial pneumothorax entitled the sanatorium to special credit, but if it was found that artificial pneumothorax was used excessively or unwisely, deductions were made on that account.

Inasmuch as the results of the ratings were frankly submitted in detail to the members of the sanatorium board and the medical staff, it became a source of considerable embarrassment to fairly rate the efficiency and intelligence of these persons. This however, was performed by Dr. Watterson with the utmost tact and with the development of little or no friction. In one instance he announced to the members of the sanatorium board that he had rated the board as 50 per cent

*The sanatorium score card of the American Sanatorium Association, based upon 100 points, allows 3 points for location and site; 5 points for plant and equipment; 18 points for institutional administration, and 74 points for medical and nursing service.

efficient on the ground that, of the three members constituting the board one had been absent from every meeting; while another had failed to attend half the meetings. Assuming 100 per cent efficiency and fitness on the part of each member of the board, Dr. Watterson successfully contended that an absent member is a 100 per cent useless and inefficient member.

Of the ten institutions inspected, one was rated as a class "A" sanatorium with a rating between ninety and ninety-five points; four were rated as class "B" institutions with a grade of from eighty to eighty-nine and nine-tenths points; while five were regarded as unworthy of classification. One rated as low as forty-eight points and another forty-nine points.

Sites Usually Satisfactory

For the most part, sites, locations, and buildings were reasonably satisfactory, the large deductions being made on account of the inferior character of medical service.

A number of months have elapsed since the making of these inspections and it is now safe to say that this one inspection has accomplished a great deal in the elevation of standards of all Illinois public sanatoriums. It was found that the more serious faults in institutional operation were due to a lack of knowledge on the part of sanatorium boards, and that these organizations were receptive of constructive advice and criticism. This was found true in driving home the one idea that every sanatorium must have a full-time specially trained medical director. The inspections served to distinctly improve the med-



Just some of the Pilgrims.

ical service of existing institutions and to pave the way for better conditions in the future.

It is to be hoped that the state department of public health, whose personnel has been materially changed by political conditions, will see the wisdom of making supplemental inspections and re-ratings. This is particularly desirable in Illinois where, according to the interpretation of the at-

torney general, the law provides that it is not necessary for a county adopting the county sanatorium proposition to actually erect and maintain a sanatorium. At its discretion the sanatorium boards of smaller counties may employ the funds raised by the special sanatorium tax in placing tuberculous patients in institutions in other counties.* The frequent re-rating of sanatoriums will not only afford reliable information to sanatorium boards in selecting the institutions in which their charges are to be placed, but will cause an elevation of standards among all county sanatoriums seeking patronage from other counties.

Intensive Educational Campaign Imperative

While the inspection and rating of existing sanatoriums have done much to improve the few institutions now in existence, they could have little influence upon the very large number of sanatoriums to be established within the next few years. To avoid the serious mistakes already being made and to stimulate intelligent action on the part of county sanatorium boards that had remained entirely inactive, a campaign of intensive education became imperative. It was impossible for the Illinois Tuberculosis Association to send competent representatives into the fifty counties having sanatoriums in contemplation, to remain long enough to win the confidence of the members of sanatorium boards and to exercise any great degree of influence. It was consequently decided to invite the members of all the sanatorium boards, together with members of boards of supervisors and county commissioners, with physicians, nurses, and other interested persons, to go on a personally conducted tour of inspection to a group of public and private sanatoriums in Illinois.

The response to this invitation was astonishing. Three Pullman cars were comfortably filled and the journey was made to eleven different institutions, occupying a full week.

Attached to the train was a large baggage car whose walls were covered with exhibits, sanatorium plans, and educational material, and this car was used as a class-room on wheels by a staff of experts in every phase of tuberculosis work. The staff included clinicians, architects, sanitary engineers, institutional nurses, institutional managers, and visiting nurses.

At each town that was visited one or two large public meetings were held under the auspices of the local tuberculosis association and the county medical society and at these meetings the members of the teaching staff gave addresses on dif-

*The uniting of counties to create district sanatoriums is unconstitutional in Illinois.



The Pilgrims of the Ottawa Colony.

ferent phases of tuberculosis work, all of these lectures being so arranged that they constituted a connected course of instruction on some thirty different subjects.

On visiting the sanatoriums, the party was divided into groups and each group was personally conducted by some one competent to intelligently criticize the institution. Then at informal meetings held in the sanatoriums, the architect, the medical director and the head nurse were requested to state the desirable features and the definite mistakes that had been made.

The number of persons taking part in this pilgrimage averaged about seventy throughout the trip; the number occasionally increasing to over a hundred. It is believed that fully two hundred and fifty persons accompanied the party at one time or another, while fifty-five completed the entire itinerary.

Great Enthusiasm Shown

In all of my experience, covering ten years in public tuberculosis work, I have never known an educational enterprise in which such keen enthusiasm and interest were manifested, nor one so directly productive of salutary results. The pilgrimage ended on May 14, and the following month there were inaugurated numerous constructive activities in many counties of the state where distinct apathy had hitherto prevailed.

In one county, where the sanatorium is not yet constructed and where it appeared to be the impression that the county sanatorium was merely a question of brick and stone and mortar, a plan has been approved for the establishment of a central dispensary under competent direction and a chain of local clinics in every sizable community.

One municipal official who manifested the utmost indifference on the first day of the pilgrimage and who expressed his intention of returning home the following day, accompanied the party

throughout the week and left with the declaration that his community would immediately establish open air schools and nutrition classes as a part of the definite Illinois county sanatorium program.

Aside from the first-hand information received by the members of sanatorium boards and conveyed to them by practical demonstration rather than by word of mouth, the eleven institutions visited were tremendously helped by the frank criticisms of the pilgrims and of the experts who accompanied them, while in every community the visit of the pilgrims gave tremendous impetus to the work being carried out by the local sanatorium boards and the local tuberculosis associations.

Attitude Changed During Pilgrimage

With the idea firmly implanted in their minds that a tuberculosis sanatorium is merely a building which can be designed by any man claiming to be an architect, and directed by any man possessing a license to practice medicine; impressed with the notion that a county sanatorium is something of a pauper institution and closely akin to the pest house, it was tremendously interesting to see the development of opinion and the change in attitude which came over these men and women as the days of the pilgrimage passed. All of them returned to their homes satisfied that medical and nursing service are infinitely more important than buildings and equipment; all of them were convinced that tuberculosis dispensaries and visiting nurse service must precede the sanatorium; all of them were satisfied that open air schools, nutrition classes, and child welfare activities are a distinct part of the program of the county sanatorium. It is my profound conviction that the Illinois Sanatorium Pilgrimage will extend its influence in the elevation of standards of institutional care in the state for many years to come.

Saw Limits of Score Card Rating

Incidentally, the pilgrims who had fully been advised as to the score card method of rating institutions, had an opportunity to see the limits of usefulness of the inspection and rating of public institutions. It was realized very definitely that there is no way by which one may reliably rate that exceedingly important, but intangible thing, the personality of an institution, and it was observed by the pilgrims that some of those institutions which were graded highest in the inspections made by Dr. Watterson failed to compare favorably with those less satisfactorily rated on account of the unfortunate personality or misguided point of view of an otherwise thoroughly competent and efficient personnel.

HOSPITAL ADMINISTRATION AND THE TRAINING SCHOOL; HOW THEY AFFECT EACH OTHER

By A. K. HAYWOOD, M.D., SUPERINTENDENT, THE MONTREAL GENERAL HOSPITAL, MONTREAL, CANADA

THERE was a time when such a title as the above would have seemed to me an opportunity to take the nursing profession to task or to air many so-called grievances against training schools. But that was many years ago, when I was beginning to learn hospital administration. At that time I was willing to pit my enthusiasm against the knowledge of training school superintendents who were exceedingly wise in their particular profession. Time has demonstrated to me most emphatically that hospital administration and training school administration cannot be separated as oil and water, but have a common interest that must be directed by both sides to the glory of the hospital as a whole.

It is not so many years ago, that the matrons of the training schools of our large hospitals were monarchs of all they surveyed, and rightly so; hospital superintendents had not learned their share of the mysteries, troubles, and joys of the matron of a training school. In many cases, the superintendent of the hospital was a layman who had grown up with the hospital, but who could never grow up with the training school, because they spoke different languages. These men were excellent business administrators, but it inevitably meant that to a large degree the training schools were forced to work out their own salvation.

Changes in Hospital Administration

The administration of a general hospital fifteen or even ten years ago, was quite a different problem from the complex situation that presents itself under that heading today. During the last decade our hospitals have been compelled to undergo many radical changes. I refer in particular to questions of policy and finances, and in each of these broad principles, the training school has a very definite relation to the administrative head.

The modern hospital administrator has done

It has been increasingly evident with the development of the hospital that the administration of the hospital and the training school are closely related, and that in many ways they react upon each other. The superintendent of a few years ago did not understand or enter into the problems of the training school. He must do this today if the hospital is to function as a perfect whole. The training school is perhaps the most important department of what is really a business organization—the modern hospital. As in a business organization the department heads must be taken into the confidence of the administrator and must also take him into their confidence if the final result is to be attained.

well to pattern his business (that of hospital management) after that of our large corporations. The old, careless, happy-go-lucky methods of conducting our charitable institutions in the past have given way to modern business methods. We look upon our hospitals today as large factories; our product is not boots and shoes, but health. We have our various departments all contributing to the manufacture of that product,

and not the least important, if not the most important department, is the training school. If these departments are to be asked to contribute their quota to the end that our product, health, may be the finished article, they must be taken into the confidence of the administrator, share his successes and troubles. On the other hand, it stands to reason that if the administrator is to be more than the nominal head of his institution, he must in turn study training school problems in general, and the problem of his own training school in particular.

Clerical Work Given to Training School

One very serious effect that modern hospital administration has had upon the training school is the large amount of clerical, or work of a purely business nature that has been placed upon it and by it distributed to the ward directresses, and in turn by them to the undergraduate nurse. A sympathetic administrator can accomplish much by education in securing this business assistance from his training school head. I mean by that, tactful consideration of the troubles and inconveniences that this work will entail. Training school heads are, as a body, reasonable people, and can be shown whereby these improved business methods are both necessary and beneficial for their hospital. Although it is very difficult at times, and impossible at others, to prove that any direct benefit will accrue to the training school, there is no doubt that there will be indirect benefit in direct ratio to the general im-

provement in the hospital. The policy of not letting your right hand know what your left hand is doing, has been tried in hospital administration and has failed miserably. If the matron of your training school is to be expected to instill into her nurses, the spirit of cooperation, so essential between the various departments in a hospital, it is necessary that she be as well informed as possible, of the problems of those other departments. This is being accomplished in several of our larger hospitals by regular meetings of the different department heads. At these meetings each one learns something of the difficulties of the other, and it is here that one looks for original suggestions for the betterment of the hospital as a whole. It would be unjust to the head of the training school to place her upon an equal footing with, say the head of the laundry, the housekeeper, or the heads of any of the other sub-departments at these meetings. However, one should endeavor to make the staff meetings as democratic as possible, always guarding against the personal element which is so liable to creep in between heads of departments whose feelings have been hurt, or whose authority has been encroached upon. At the same time the dignity and importance of the training school should be impressed upon all in order that they, in turn, may carry into their departments and to their employees, be they mechanics, servants or clerks, the proper sense of courtesy and deference which our training schools have earned in their development from the day of "Sarry Gamps" to the, may we say, finished product of today?

New Subjects Added to Curriculum

The modern hospital has added many departments to its organization of recent years. This has been made necessary in order to cope with the advances made in medicine. We have hydrotherapy, physiotherapy, metabolism, social service departments, and a host of others in addition to special clinics, such as nutritional clinics for children, child welfare, diabetic, fracture, and venereal disease. These are all necessary in modern healing, but they have made serious inroads into the training school. There are very few hospitals that have not been compelled to increase their proportion of nurses to patients, to keep pace with these modern methods. Here we have one very good reason for the shortage of nurses that seems to exist at the present time. The establishment of so many of these departments by our hospitals has necessitated in turn a serious increase in the instruction given to an undergraduate nurse, until at the present time we have training school matrons wondering how on earth they can get time to add this or that new subject

to their curriculum. One cannot resist sounding a note of warning to guard against our nursing curriculum becoming too much theory and too little practice. One hears so often nowadays that the present day nurse does not compare favorably with her predecessors of ten years ago. I do not agree with this, but I feel that modern hospital administration does seriously affect the training school by the addition of these new departments which we are so frequently adding to our organizations.

Poor School Usually Means Poor Hospital

I cannot help feeling that the hospital administrator of recent years has exerted a considerable influence over the destiny of the training school of his particular hospital. We know that there are good schools and poor schools, but we also know that it is seldom that one finds a poor training school without finding that the rest of that particular hospital is considerably below standard. A good training school can exist in a poor hospital, but its existence will be of short duration. It can exist only by the almost superhuman efforts of an excellent matron. There are a hundred and one petty troubles that confront the matron daily, but in my opinion, many of these troubles can be partially solved or shouldered by the administrative head of the hospital. If the matron has the confidence and respect of the superintendent, and vice versa, I feel convinced that the effect of hospital administration on the training school will not only be beneficial but pleasant.

Let us look for a few moments at the other side of my subject—the effect of the training school on hospital administration. The points which I have tried to make regarding the placing of so much clerical work on the training school were for the purpose of showing the effects of the administration on the training school. On the other hand the ability or inability of the training school to carry out this work, has a still more serious effect on the administration of the hospital. Local conditions will in many cases govern in the community. At the Montreal General Hospital we call upon the training school for assistance in many ways. We have a system of keeping our patients' accounts which calls for daily reports from departments such as operating rooms, surgical supply office, etc., all of which are prepared by the nursing staff. These are not always correct, but lest I be misunderstood, I must state that every endeavor is made by the training school to have them rendered promptly and correctly. The listing of patients' clothes and valuables, the requisitioning of supplies, or requests for repairs—all clerical work at present done by the members

of the training school, brings the training school into intimate contact with the administration of the hospital. It naturally stands to reason that the administration of an institution which employs these methods will be more or less at the mercy of the training school. Nurses in training and even graduates in charge of wards must have a working knowledge of the administrative methods with which they are being asked to assist. Unfortunately for the administrative side of the hospital, the constant changing of the personnel of the training school causes many breakdowns in the assistance they are asked to render.

Nurses Need Some Administrative Training

One hears so often the criticism that the nurses are for nursing only, and their services should not be commandeered for administrative purposes. I can assure you that with the present shortage of applicants for training schools in North America today, he would be a very short-sighted superintendent who would impose upon the training school any work apart from nursing, that was not necessary. Yet, on the other hand, many of your present undergraduates are some day going to be the future training school heads, and it is vital to them that at least a small working knowledge of these problems be obtained while in training.

Hospital administration is not a sinecure. Medical men have not yet realized the future of this branch of work. It must not be looked upon as a position to be occupied by medical men who, having failed in private practice, enter this branch in order to eke out a living with the least amount of effort. That has happened before, and that is one of the main reasons why it is so difficult to secure medical men as assistants. If this continues it will not be improbable that our large hospitals will have at least one assistant superintendent, a trained nurse, and probably more. I cannot help feeling that this arrangement would bring to the administration of the hospital many advantages and make for a still closer cooperation between the training school and purely administrative departments.

Eight Hour Day Entails Many Changes

The movement that is slowly but surely spreading over this continent for an eight hour day for nurses in training, has undoubtedly given many a hospital superintendent much cause for worry. I think I am safe in stating that the policy of an eight hour day is now generally accepted as reasonable and fair. There are still many of our large hospitals that have not adopted it, not from any lack of desire on their part, but because of the

demands that this change would make on their annual budget, and available accommodation. It means in many cases new quarters being erected for the additional nurses required, and a considerable increase in the pay-roll in hospitals where undergraduates are paid a monthly or annual honorarium, to say nothing of the additional expenses which this increase in the nursing staff adds to practically every department. The superintendent that has to face this change to an eight hour day, realizes only too well, if his accommodation is limited, that this is one of the training school problems that it is going to have a most serious effect on hospital administration. Coupled with this is the general movement in all our large hospitals for a betterment of general living and social conditions for our nurses in training. The modern young women that come to our training schools are not going to stand the semi-slavery conditions that have existed in so many places in the past. They demand that justice be tempered with mercy, that in being called upon to do a grown woman's duties, they be treated as women—that opportunities be provided, within reason, for recreation and social life. These problems are dealt with by so-called training school committees in many hospitals, but the training school problem is becoming one of such magnitude that our hospitals are gradually employing administrators who will study the problems of this department as they would any other department of the hospital.

School a Professional Institution

Not all of the effects of the training school on hospital administration are either pleasant or beneficial. Traditions have instilled into our training schools a well earned and well merited feeling of superiority. There is no doubt that in a properly governed school the discipline among the nurses will be superior to that of many of the other departments of the hospital. In addition to this commendable asset the training school is a professional institution and rightly demands professional respect. It is these various attributes that contribute every now and then to some of the worries and pleasures of the administrative head. I do not think that hospital employees are thin skinned but it is a remarkable fact how frequently one is called upon to settle some misunderstanding between some member of the training school and the housekeeper, engineer, foreman, dietitian, or steward. My experience has taught me that in the main the training school is correct, but some of the judgments that the administrative head is asked to render would seem to require not only all of the wisdom possessed by Solomon, but also the patience of Job.

THE BROOKLYN DIAGNOSTIC INSTITUTE

By JACOB GUTMAN, M.D., PHAR.D., F.A.C.P., BROOKLYN, N. Y.

AS A natural consequence of the growing appreciation of the advantages of the collaborative study, or group diagnosis, of disease, those who have played a part in its development are frequently called on for such suggestions as may prove helpful to others in extending the facilities for the prosecution of this branch of medical service.

As founder of the Brooklyn Diagnostic Institute, the first of any magnitude to be established in the East, it has been my lot to receive a great many inquiries relative to the organization and



Reception Room

conduct of diagnostic institutions, and also to become acquainted with the obstacles encountered by those who take the initiative in placing these at the service of the clinician.

It is thus the design of this paper to import such information as may prove conducive to a better understanding of the precise functions of a properly conducted diagnostic institution and to serve as a reply to the numerous inquiries received from many sources. By limiting myself to the citation of a specific example and only describing the organization, scope, and other vital issues of an institution already established and in full operation, the Brooklyn Diagnostic Institute, I hope to avoid immaterial discussion, and indulgence in generalities.

In a previous article¹ the advantages and superiority of group diagnosis have already been discussed and will not be dwelt upon in this presentation.

The resolution to establish a group diagnostic institution originated with the writer in 1908. Inspired by the wonderful achievements in diagnosis at several sterling medical centers in the Western states, he decided to establish a similar institution in his own locality, the state of New York. Realizing that no cooperative organization of specialists, even of the highest type, is in a position to offer the best of services and guarantee success without the interpretation of the conclusions by an experienced, broad-minded and competent internist, for "after all, there is no use in a lot of data brought together by a group of men unless there is some one individual able to sum up the information accumulated by the group," the founder decided to enrich his diagnostic skill by postgraduate studies abroad. At the University of Vienna, with Eppinger, Biedl, Van Noorden, Singer, Frankel-Hochwart, and other eminent diagnosticians, so as to prepare himself fully for his part of the work, before proceeding to the actual organization of the proposed institution. Having supplemented his work abroad with a study of various hospitals and institutions, he laid the foundation of the present establishment in the borough of Brooklyn. The decision to organize the institution in this borough was based on the fact that this residential part of greater New York has not, as was the case with the borough of Manhattan, already become the homes of scores of commercial diagnostic laboratories.

During the first few years of its history, the quarters of the Institute were small and devoted



Library

1. Gutman, J., Group Diagnosis, Med. Record, May 15, 1920.

entirely to laboratories, patients being sent for examination to the offices of the different members of the staff. In due course, another very much larger building has been acquired, and altered to accommodate a number of specialists' departments, fitted with all requirements to facilitate their work. Thus, at last, all attributes of a modern group clinic had been instituted, provision having been made for the examination of patients under one roof, by capable specialists in an expeditious and practical manner.

The Institute is now located in a most exclusive but easily accessible residential section of the city. It occupies the entire five-story building, with a floor space of about ten thousand square feet. It provides abundant space for the heads of the departments. The first floor is devoted to the serological, microscopical, chemical, and bacteriological laboratories, x-ray, and dark rooms. The main floor is occupied by the director's office, reception rooms, and the medical department. On the next floor are located the library, cardiological, ophthalmological, cystoscopic, and gynecological departments. The entire floor above is devoted to physiotherapy, gymnasium, electrotherapy, Zander treatment, baths, and thermother-



Bacteriological laboratory.



Medical department.



Consultation room.

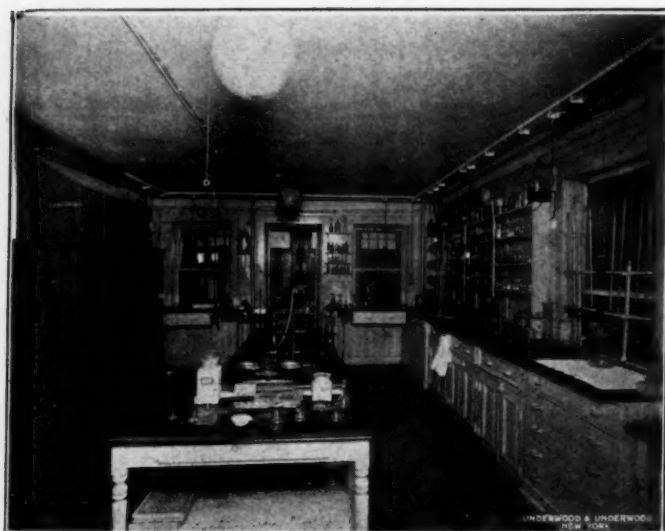
apy. The top floor is utilized for rest rooms and solarium.

The equipment of every department is most complete and comprises every scientific instrument in use—electrocardiograph, polygraphs, metabolism apparatus, colorimeters, polariscopes, every conceivable apparatus required for x-ray diagnosis, cystoscopy, ophthalmoscopy, proctoscopy, clinical chemistry, etc. The library

contains several thousand volumes, and all the leading periodicals devoted to the different branches of science.

The staff of the Institute is made up of sixteen clinical directors, assisted by the highest type of laboratory technicians and associates. A limited number of associates are appointed each year to the Institute. Active practitioners in good professional standing are eligible to such appointments. Associates to the Institute are privileged to assist in its regular research work, to present and discuss papers, to receive diagnostic service for themselves and their immediate families, and to be compensated for service rendered by special arrangement, on a cooperative basis.

The scientific administration of the department is vested in the clinical directors; the executive function in the director of the Institute. None of the members of the staff are burdened



Chemical laboratory.

with any financial responsibility; all capital obligations and responsibilities are assumed by the founder of the Institute. The clinical directors receive ample compensation for their services, independently of the institution's income; the associate members are remunerated for their services by sharing cooperatively in a fund derived from the excess income of the Institute. It is aimed to have the institution self-supporting and independent of private donations, contributions, or endowments, upon which most other organizations depend. Neither is it purely for gain, hence the fees for services are arranged with this point in view and are only sufficient to sustain the institution and provide for the proper compensation of its staff and employees and normal expansion.

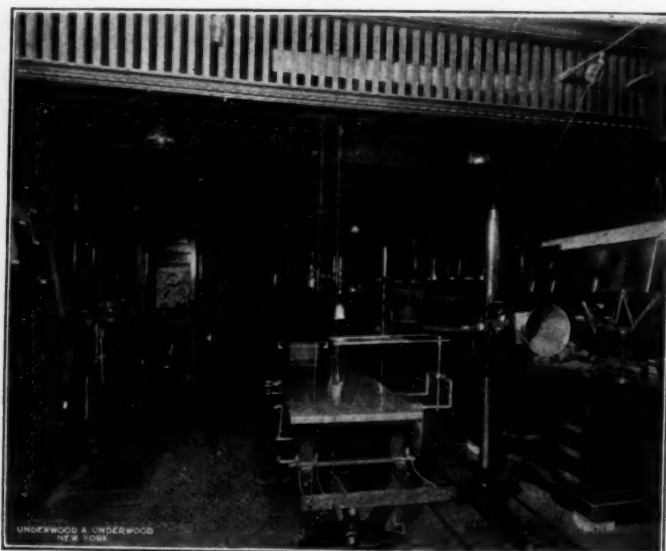
Staff meetings are frequent, in order that the collective findings of the directors of the differ-

ent departments may be had in any case referred to the department. Lectures are given by the directors of the various departments, to which members of the medical profession are always welcome.

Every general case is subjected to a classical examination which includes a morphological study (pathological), an examination of the excretions (chemical), and functional tests (endocrine); in short, a determination of the precise nature and degree of every structural and functional deviation from normal. The individual findings of the various members of the staff are referred to the internist, who, after taking into consideration the history and all other data, prepares the conclusions and such suggestions as are deemed appropriate. "Successful practice is never possible unless the patient is considered as a whole, with a



Serological laboratory.



Roentgenologic department.

mind and body, rather than what is in effect regarding him as a bundle of associated organs; therefore, the head of the diagnostic clinic has to possess certain qualities, which, it seems to us, are very closely related if not identical with those developed by the first class general practitioner in the course of his own practice."²

The cardinal principles of the Institute are:

1. To hold at the command of the general practitioner the highest type of diagnostic skill.
2. To be scrupulously observant of the loftiest standards of professional ethics.
3. To perpetuate the identity of the patient, whom the clinician refers for examination.
4. To give no information to patients under observation, but to embody the results of every investigation in a report to the physician of record.
5. To offer no therapeutic suggestions unless requested by the referring physician.

2. Editorial, MODERN MEDICINE, November, 1920.

6. To permit the physician of record to take part, if he desires, in the study of a case.

7. To permit the clinician to assist members of the staff in research work.

8. To give the clinician the option of referring a case to any single department or for any analysis, but in the absence of specific instruction, to have the staff determine the extent of all examinations.

To provide for the indigent class, unable to avail themselves of the Institute's facilities at the regular fees, one day a week has been assigned when services of the staff may be had as on other days, for a nominal charge.

All such cases are subdivided into four classes, gastro-intestinal, pulmonary, cardiac, and renal, and are treated accordingly.

To fulfill the needs of local internists, who understand the necessity and incalculable value of physical therapy in the alleviation of chronic disease, this institution has added to its diag-



Thermotherapeutic department.



Otolaryngological department.

nostic facilities a department of physiotherapy. Whereas, the care of surgical and acute medical cases is amply provided for by the existing hospitals and sanatoriums, the treatment of chronic ambulant cases is sadly neglected because of the lack of physiotherapeutic facilities, indispensable in the care of these cases. Such neglect prompts the chronic sufferer to seek the aid of "irregulars" whose therapy is essentially physical, and, not infrequently, unscientifically applied, and to abandon the regular practitioner. To obviate such a state and remedy this defect, the Brooklyn Diagnostic Institute has established a department of physiotherapy, equipped with every known modern appliance (Zander apparatus, gymnasium, electro-, thermo-, balneo-, therapeutic apparatus, etc.) for the accommodation of local practition-

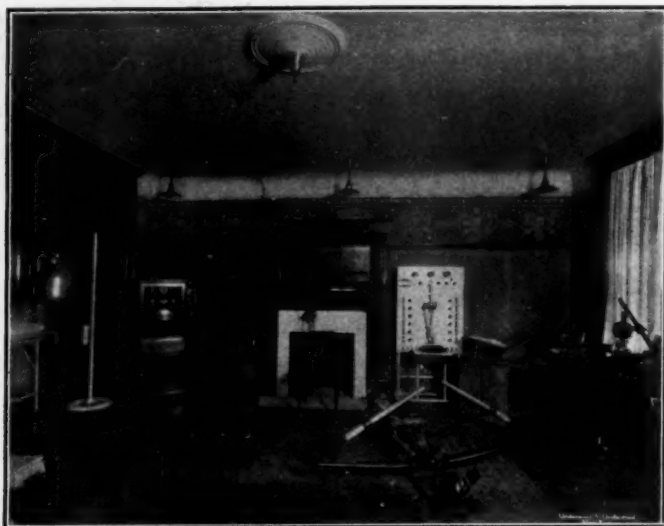
ers. Physicians may refer their cases to the Institute for such therapy as they deem necessary; associate members are privileged to invite and treat their own cases.

There can be no gainsaying the fact that the organization of diagnostic institutions possessing sufficient variety and quality of facilities to meet modern requirements does, as a rule, excite some opposition on the part of a limited number of local practitioners. But this opposition is based solely on a mistaken conception of the well-defined limitation of what is now meant by the term "diagnostic institution."

Opposition to the establishment of a diagnostic institution is based, in the main, on the contention that the modern hospital possesses all the necessary facilities for diagnostic investigations, and that, consequently, a disconnected institution devoted exclusively to this special branch of medical science is needless, if not an



Cardiologic department.



Electrotherapeutic department.

actual hindrance to hospital staff efficiency.

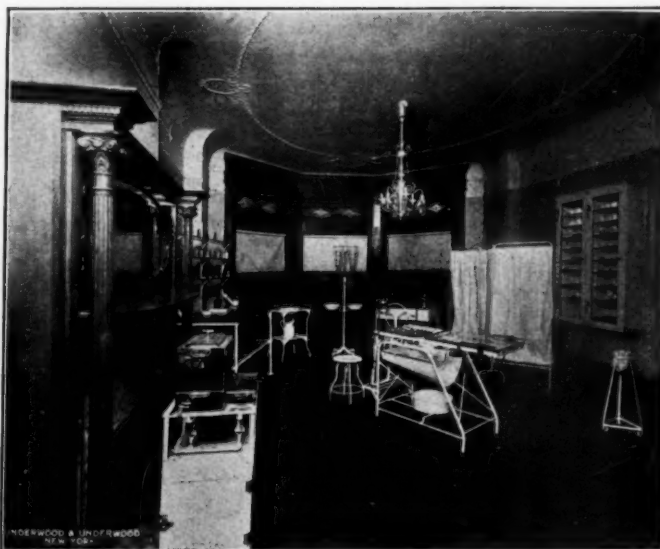
Time was when such a contention might well have been accepted as valid. But in this day of highly specialized training and better understanding of the importance of proper environment, it is entirely unjustified. In spite of their manifest interdependence, the clinician and the laboratory diagnostician work to the utmost individual advantage when in contact with their own kind, in separate environments. The clinician is at a disadvantage just so long as there remains in his mind the slightest uncertainty as to the nature of a given condition, and the laboratory diagnostician is at an equal disadvantage whenever he is permitted to share interest in the result of his treatment.

In the hospital, regardless of the scale of its departmental equipment, everything is subordinated to the restoration of a given case. Accordingly, the "atmosphere" of the hospital is that which acts as an incentive to the earliest and best possible discharge of the case. But in the diagnostic institution, everything is subordinated to the determination of the precise nature of a given condition, and the atmosphere is that in which a collaborative investigation to this end can be made under the most propitious circumstances. The skill of the clinician is brought to its peak by keeping him in contact with others,

trained in their special field of activity. And the same holds true in the case of the laboratory diagnostician. The sum of experience is, that technical exactness and advancement are always greatest where contact of highly specialized minds is preserved.

Such flexible or imaginary boundaries of activity as are imposed on members of the staff of a hospital are a hindrance to individual efficiency and tend to lower the standard of institutional service. A biochemist should not be required to make a bacteriological investigation, nor should a morphologist be permitted to make a chemical analysis. And what is still more important, the accuracy of the investigations of a laboratory diagnostician should not be jeopardized by any interest on his part in what is beyond the prescribed limits of his own responsibility. When the clinician comes to

understand that the collaborative study or group diagnosis of disease consists in assigning highly specialized minds to distinct branches of investigation, and the converging of their respective findings to a single conclusion, he will no longer consider it deserving of anything less than independent facilities; he will then realize why a diagnostic institution, in the modern acceptance of the term, bears nothing in common with



Cystoscopic department.



Gymnasium

the laboratories of the best equipped hospital.

Since experience has shown that it is an advantage to society and to medical science to assemble specialized talent and facilities for the treatment of, say, only neurological, ophthalmological, or gynecological cases, it must follow that it is equally advantageous to assemble other kinds of

specialized talent and facilities for the single purpose of collaborative study, or group diagnosis, of disease. It is well to bear in mind the fact that a hospital is of benefit to only those who can enter its wards, whereas the service of a diagnostic institution is not limited to the bed-ridden, but is accessible to ambulant cases.

THE ORGANIZATION AND MANAGEMENT OF HOSPITALS

BY H. C. WRINCH, M.D., HAZELTON, B. C.

THERE are two principles that have been of late very much emphasized in all recent writing and discussion in the broad field of hospital development. One of these principles cannot be overworked, and cannot be too persistently drilled into the mind and thought and action of every hospital worker. It is included in the simple expression "highest efficiency." Concerning this principle, no further comment is necessary. It is accepted by everyone.

The second important consideration finds expression in the term "hospital standardization." This also has come to stay, and is becoming the means of accomplishing much in bringing our hospitals up to the condition of highest efficiency.

It is the purpose and endeavor of this paper to add its bit to the development of hospital efficiency. To this end the principle of standardization will be advocated as far as it can be pressed into service, but with the clear understanding that it is a means rather than an end.

Local Conditions Must Be Considered

Having thus given pledge as to orthodoxy, the next principle laid down is that full recognition should be given to local conditions and requirements, especially wherein they differ from the ordinary. Even in arrangement of accommodation in building, local requirements should be considered. For instance, in an industrial plant where male workers predominate, with few women and children in the community, a hospital will be required with principal accommodation of public or semi-public character. On the other hand

"Highest efficiency" and "hospital standardization" are much used terms at present in any discussion of the principles of hospital development. The first is accepted by everyone. The second also must be accepted, and in the development of hospital efficiency hospital standardization must play an important part. It is a means to an end, however, rather than an end in itself. With due regard to local conditions and differences of service, some constituted authority should check or regulate hospitals. Such regulation, even of private institutions, is justified for the public good. Yet the regulation must be such that the interest of the immediate community in the hospital will be stimulated.

in a farming community, where the population is mixed in the normal degree a hospital will require more private and semi-private rooms for care of illness incidental to family life.

And of course the hospitals to be devoted exclusively to the care of special diseases should be designed and built so as to give the best conditions possible for the care of such patients. There may thus be three, or even more, hospitals of

equal capacity, each requiring different internal arrangement to be best adapted to its particular purpose.

It is a remarkable, and surely an anomalous condition, in an age such as the present, when governmental control or regulation is brought to bear in so many ways in order that the rights and safety of the public should be safeguarded, that an important service such as that of hospitals should have been virtually ignored in many cases by "the powers that be." Certainly there is no service more vital to the well-being of our whole community than that in the hands of the hospitals. And yet, in so far as check or regulation by constituted authority is concerned they have been left to be originated, developed, and carried on, in very many instances, according to the ideas of individuals, private corporations, publicly or semi-publicly elected boards of trustees, in fact in any way whatever as local conditions appeared to demand, or permit, as the case might be.

And this refers only to the negative aspect of the situation, the regulation of such institutions as have been brought into existence by independent methods. It is too utopian to conceive of

a condition where constituted authority comes into a community and states that the population warrants, and its best health interests demand the establishment of a hospital within its limits? An established policy such as that would automatically prevent the independent action which has in the past, only too often, resulted in the establishment of small hospitals at points, or under conditions, which from the first precluded any possibility of success.

Small Hospitals Have Been Invaluable

Lest there should be any misunderstanding, I desire at this point to pay tribute to the invaluable services that have been rendered to our communities by the many hospitals by which they have been, and are still being, served. The credit to be accorded to the many persons instrumental in conducting our hospitals, should be all the greater because they have had to work so much of the time comparatively single-handed, negotiating innumerable difficulties, and breaking trails for themselves, and their way might have been made much smoother and many pitfalls avoided had there been an experienced hospital commission or committee "with power" to advise them and direct their efforts.

To my mind the first and by far the most important feature in the organization and management of our hospitals, big and little alike, is the bringing into existence of a wisely selected committee or commission on hospitals. That they should be persons of broad hospital knowledge and some experience goes without saying. They should be ultimately responsible to the local government, although not necessarily directly appointed by that body. In fact it would seem more reasonable that they should hold appointment under a council of hospital workers, organized along lines similar to the medical, legal, dental, and other councils.

Such a commission should have authority to inspect and examine closely into the methods and working of all hospitals, large and small, public and private, within its territory. It should, above all things, be sympathetic and constructive in its criticism. It would naturally decide upon certain standards. These standards would necessarily be graded according to the capacity or special object of each hospital, but should be such as would ensure to every patient admitted the best possible treatment. This might involve transference of certain patients to larger centers or larger institutions where more highly specialized equipment would be available. An institution that was found willfully ignoring the need of a patient for treatment such as it could not furnish, and holding him, either by misleading advice or by taking ad-

vantage of his ignorance, would be subject to censure or other pressure by the commission.

It may be claimed that such a course could not, or should not, be applied to private concerns. It would be an unwarranted intrusion upon private interests. The answer to this is that private interests must be secondary to the public good. No one can be allowed to trade in the greatest asset of the state, that is, the health of its citizens.

The only exception to the carrying out of this principle would be in the case of the patient himself, who might refuse to be transferred to another institution.

Having arrived at the conclusion, with the approval of the hospital commission, that a hospital should be opened at a certain point, the question of its organization in relation to the community becomes the most important matter.

Some would settle the whole question for all hospitals and for all time by vesting the entire responsibility, control, and administration in the government, but while this would appear to be the easiest way out and in many respects the most equitable, there are not a few persons who see in the system some very serious drawbacks.

Should Secure Personal Interest

A system that would best ensure the active personal interest of every member of the community to be served must be admitted the ideal one. The local administration should be vested in the people of each hospital community. A system of appointment of the board of management patterned somewhat after the school trustee system of British Columbia would serve the purpose. The honor of the position and the privilege of contributing to the welfare of the community should be sufficient inducement to enlist the services of the most broadminded persons in the district. An honorarium for partial or full time of one member of the board who would be responsible for secretarial or other necessary work, where it involved more time than could be reasonably afforded gratis, would satisfy the situation in cases where such conditions existed.

In comparison with the above system, the hospital organization under control of any philanthropic body, whether religious, fraternal, or otherwise, is handicapped in that it enjoys the active sympathy of only a portion of the people of any community. No matter how disinterested the motive behind the hospital project in these cases, there are but few that will escape criticism, or the imputation on the part of some, that there is some ulterior motive on the part of the organization concerned, for the furtherance of which the hospital has been thrust into the field. A very little of such adverse suggestion is sufficient to alienate

a considerable portion of the local interest which the hospital needs and to which it is fairly entitled.

Similarly the institution controlled and directed entirely by the government, with all appointments made by political methods, would meet with as much or even more indifference on the part of the general public.

It means a very great deal to the success of the hospital that it shall be so organized that every person in its district may think or speak of it as "our hospital." To my mind these conditions are best met when the hospital is under the direction of a local board of management, which is appointed in some manner by the people served by the institution.

It can be readily seen that the matter of financial support also, an all-important feature, although its discussion does not come within the scope of this paper, becomes an easier undertaking under this suggested organization than under almost any other method.

This organization should be found applicable, in a modified form to hospitals of any capacity.

Must Consider Size of Hospital

As to the management of hospitals there is probably more diversity of opinion than over almost any phase of hospital work. In this particular respect, the capacity or size of the hospital must be taken into account.

It is being more and more recognized that the position of a hospital superintendent is one requiring a more widely diversified range of ability, or even talent, than almost any other conceivable work. The superintendent of a large hospital holds a very important relation to the disbursement of very many thousands of dollars annually, hence he should be something of a financier, and be as able in seeing that the best value possible is obtained for the hospital's money as he is in devising or carrying out measures for obtaining it. He is in personal relation with a very large staff of employees, in widely diversified forms of work. In addition to this, which is a part of the task of the manager of every large business concern, the hospital superintendent is handling, as his raw material, a mass of humanity in the most difficult and often unreasonable form in which it can be found. Further he should be familiar with quality, value, and market fluctuations of a very wide range of commodities, in itself no small task. And by no means last or least, he should have a working knowledge of a group of complicated and highly specialized sciences, by means of which his associated staff are working upon this raw material, in the endeavor to turn out a finished product of health and happiness in the guise of a

grateful clientele composed of convalescent patients.

Can anyone conceive of a stronger plea for a thorough training by years of experience for so responsible a position?

But to return to the detail of our subject. The superintendent of the larger group of hospitals should certainly be medically trained, and a man of experience, drawn from similar successful service in smaller institutions.

The superintendent of the twenty-five to one hundred bed hospitals should also be medically trained. Prior to receiving appointment in charge of such a hospital he should have experience of hospital administration acquired by a certain period of service on the staff of some other hospital, perhaps as an intern, and preferably also as an assistant superintendent, or head of some allied department where his capacity as an administrator may be tried out and developed.

There is a feeling that a special course of training should be instituted for hospital superintendents. Perhaps such a course would be valuable, and without doubt it would be if supplemented by the training through experience described above. But it is certainly open to question whether the special course of training without experience of successful work in a smaller sphere would justify engagement for the larger positions.

A question may arise as to whether there is sufficient work in the hospital of twenty-five to fifty beds to find profitable employment for a trained medical man, for if engaged by the hospital, and with outside doctors on the staff, he must not engage in private practice. The answer is that in the smaller hospitals of this group, the medical superintendent who is presumably a young man, can take over some of the duties performed by interns in the larger hospitals, or carry out some of the treatments usually given over to special operators. Among such duties would be administration of anesthetics, laboratory work, x-ray and other electrical treatments, supervision of case records, etc. Many of the practitioners in attendance at the hospital would be more than glad to be able to have such work done for them in the small hospital, as it is in the larger ones, and would welcome a medical superintendent who would work in harmony with them along such lines.

Trained Nurses in Small Hospitals

The third group, that of hospitals of less than twenty-five beds, would be hardly large enough to warrant asking a trained medical man to devote his full time to their superintendence. Such hospitals are now being very satisfactorily superintended by experienced trained nurses. It is not likely that this system can be very greatly im-

proved upon. For these positions, however, it is equally important that candidates for them be prepared by training and experience as assistants in larger hospitals.

In these smallest hospitals the woman superintendent would naturally combine with her other duties the direction of the nursing as well as of the kitchen department. In this way her time could be profitably occupied in a manner that would not be feasible for a medical superintendent, unless the position was held by a woman. This latter alternative might after all be the solution of the problem as to how every hospital should be under the direction of a medically qualified superintendent, which the writer believes is the ideal condition.

The discussion of management in the further detail of the various departments, with their chiefs and assistants, becomes a matter of adjustment according to requirements based on capacity of accommodation. The matter of instituting a sufficient number of departments, and having them adequately manned so that no one individual is either overworked or idle, is after all only a part of the duty of the medical superintendent. It is to him the trustees must look for the smooth-running of the hospital machinery, or at least the human element which enters into it. The board of management that finds itself continually harassed by friction among the employees or by constantly recurring difficulty in keeping the responsible positions on the staff satisfactorily filled, may look for the cause in one of three conditions, either (1) they are not providing sufficient means to secure the best individuals for the various positions, or (2) they are perhaps hampering the superintendent by not giving him a free hand in engaging and dealing with the employees, or (3) the superintendent lacks something of the required amount of tact, personal magnetism, or ability to get the best effort out of his employees. If the board is conscientiously satisfied that the fault does not lie in either the first or second condition, then it should very seriously consider a change of superintendents.

Staff Meets With Trustees

A method adopted and found productive of exceedingly beneficial results, was that of having a monthly union meeting of the medical staff with the trustees. This proved a great success in creating a sympathetic atmosphere. The plan is that as many as possible from every department come together at stated intervals, and spend an hour or perhaps two in considering means of avoiding interdepartmental friction, and promoting cooperation, with a view to improving the combined service of the institution.

The service to be reasonably expected at any hospital depends less upon the bed capacity of the institution than upon the number of specialists, in addition to the general practitioners, who are practicing at points convenient enough to permit them to attend the hospital. The hospitals in the larger group can, and are of course expected to furnish treatment, both medical and surgical, in every form approved by the latest developments in medicine and surgery. They are able to do this because they are located at the larger centers of population, where specialists in all departments are in active practice. Such specialized forms of treatment are equally available to the smaller hospitals situated within easy access of such a town or city.

The service in the two lesser groups of hospitals is necessarily more limited for the reason that such hospitals, or most of them, are located in smaller towns and rural centers. In such places it is obviously impossible to provide the more highly specialized treatments carried out by specialists. Thus hospitals are limited in range of service to such as can be furnished by the general and surgical practitioners on their visiting staff, supplemented by what can be carried on by the trained members of the hospital staff.

Small Staff Can Handle Special Treatments

It is quite feasible in hospitals of about fifty beds, with a visiting staff of five or more practitioners who are working harmoniously, to carry out a fairly wide range of special treatments. It could be arranged if the visiting staff would agree among themselves each to take up a certain specialty, and then fit themselves for that specialty by a moderate period of training of a postgraduate character.

The medical superintendent of such a hospital, if a man of tact, could show the medical staff the great mutual advantages that would accrue both to themselves and the hospital by such a course. He would be a specially effective factor in the development of such a scheme if he would himself become responsible for such of the technical work, before referred to, that the visiting staff would be glad to have done for them. A point to be carefully guarded is that the income of the superintendent should be derived entirely from the funds of the hospital, and not from fees for carrying out any of these treatments. Any fees for such treatments should go directly to the hospital funds.

A policy on some such lines should be the means of creating and maintaining such cordial relations between the hospital superintendent and the attending staff as would enable them together to render the best possible service to the community.

THE PLASTER ROOM

By WILTON H. ROBINSON, M.D., ORTHOPEDIC SURGEON, SOUTH SIDE HOSPITAL, PITTSBURGH, PA.

THE progress of orthopedic surgery in the last decade has included the development of some very excellent pieces of temporary apparatus. A few examples are the Lovett Removable Jacket and the Abbott Jacket, both for scoliosis; the Plaster Splint (Buchanan), the Jones Abduction Splint for the upper arm; the Thomas Splint with its endless possibilities for modification; various splints of sheet metal or wire mesh; the Pylon, used so extensively in England during the late war to induce early walking in the amputated. In addition to these there is an almost infinite variety of devices of a mechanical nature for the treatment of various types of fracture of bones and for maintaining proper position of extremities in spinal or peripheral nerve paralyses. Apparatus of this kind cannot be properly made or applied without some sort of special facilities. Therefore, it is desirable that the orthopedic department set aside one room for plaster and mechanical work. The advantages of such a room are probably obvious to anyone—but it may be mentioned as an excuse for the appearance of this article that it is a very rare thing to find in the average hospital sufficient equipment and tools outside of the engine room for the construction of the simplest splint.

Of course, there are special hospitals having their brace shop in the basement and with a plaster room in the operating room suite but this is something beyond the average institution. As a general hospital proposition, the need has been met at the South Side Hospital of Pittsburgh by the installation of a specially equipped room under the orthopedic service but, of course, available to any other service.

The main consideration was to bring as much of the plaster of Paris work as possible to one place and, if possible, at given times. It was also planned to bring to this room such simple bench equipment and tools as to render possible the emergency construction of any splint or other simple apparatus that might be needed.

The equipment consists of a cast table, an Ab-

bott Frame, an upright suspension frame, a combined plaster bench and bin, and a mechanic's bench, the latter provided with a heavy vise, anvil and bench shear. There is a sink in one corner connecting by its drain with a large trap in an area way; this trap will take care of any excess plaster of Paris which gets into the drain. The taps over the sink are placed about twenty inches above its rim so that water may be run into any basin or bucket without having to tilt it.

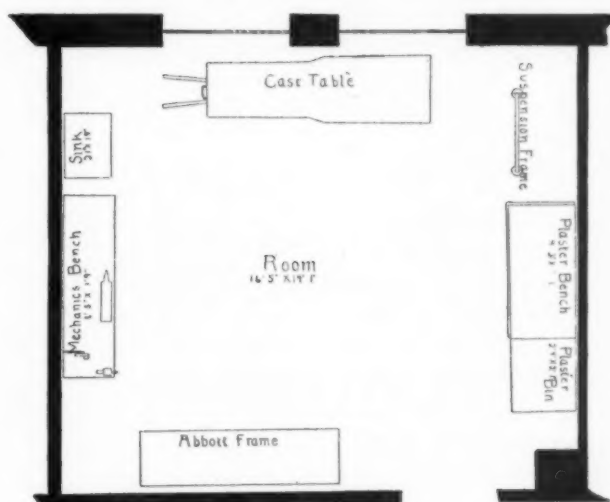
The plaster bench includes, on one end, a cupboard or bin twenty-eight by twenty-four by thirty-six inches, this being large enough to contain one barrel of plaster of Paris which may be put in at a door in the front; the top of this bin opens upward to give access to the plaster when needed. The top of the bench proper, that part to

the left of the plaster bin, is surrounded by an inch and a half coping to prevent plaster of Paris falling on the floor; the space under this part of the bench is closed in, has one shelf and a double door at the front and furnishes space for supplies; the dimensions of the bench proper are fifty by twenty-five by thirty-five and one-half inches. Some of the advantages of this type of plaster bench are: plaster

of Paris is protected from atmosphere and in case of a long continued spell of wet weather may be kept at its best by burning an electric bulb in the bin, the heat of which is usually sufficient to drive off any excess moisture; convenience of having plaster just where bandages are to be made; last, but not least, having just one definite spot to make all plaster of Paris bandages.

Hospital Has Specially Equipped Room

The equipment of tools for such a room will depend on the work to be done. In our case we use the room only for making and applying the more temporary apparatus of plaster of Paris, with or without metal parts, in making simple splints or occasional changes in braces after they come from the instrument maker or brace shop. For this purpose the following tools are sufficient:



Plaster room, floor plan.

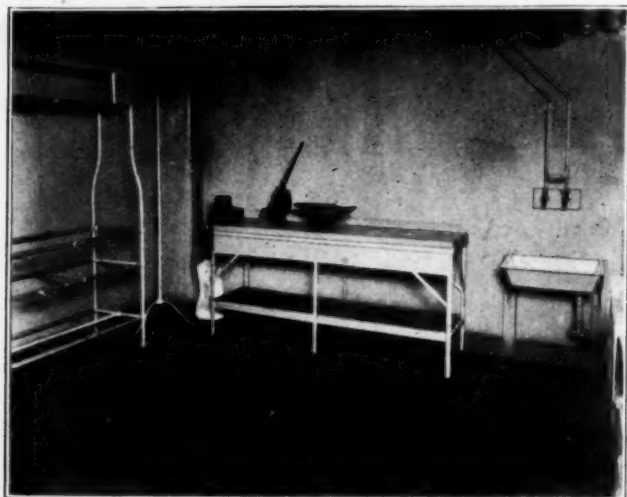


Plaster room, showing plaster bench and upright suspension frame.

- | | |
|----------------------------|----------------------------|
| 1 heavy hammer. | 1 light ball-pean hammer. |
| 1 cold chisel. | 1 lead block (about 5 lb.) |
| 1 6-in. crescent wrench. | 1 screw driver. |
| 6 drills and corresponding | 1 hand or breast drill. |
| taps and wrench. Twist | 3 punches to correspond to |
| drills, number 9, 16, 23, | drills, number 16, 23 and |
| 29, 34 and 43. | 34. |
| 1 draw knife or old catlin | 1 pair bending irons. |
| (for trimming torso | 1 leather punch. |
| models). | 1 U. S. standard metal |
| 1 sewing awl. | gauge. |
| 1 or 2 files. | 2 or 3 linoleum knives. |
| 1 10-in. pipe wrench. | 1 grommet set and grom- |
| 2 or 3 shirt knives. | mets. |
| 1 saw. | |

The above tools should be kept locked up, preferably in a tool chest of some sort. Many of the articles resemble things used by mechanics about the hospital and mistakes may happen.

As small a stock of supplies as possible should be kept on hand in the plaster room. It should not become a storeroom. An excessive amount of supplies only leads to unnecessary expense through waste or soiling. While the following list may appear limited, it is enough, under ordinary circumstances, to have about:



Plaster room, showing mechanic's bench.

- | | |
|------------------------------|-------------------------------|
| 1 barrel French's dental | 6 bolts crinoline. |
| plaster. | Stockinette tubing in 3, 6, |
| 1 yard white cornplaster | 8 and 12-inch sizes. |
| felt ½-in. thick. | 10 or 20 feet iron rods, 3/16 |
| 10 or 20 feet hoop iron in | and ¾ inches diameter. |
| ½, ¾ and 1-inch widths. | Gauze and muslin bandages. |
| Moleskin and plain ad- | Some sash cord and trac- |
| hesive plaster. | tion blocks. |
| 3 or 4 yards 10-oz. canvas. | 1 roll lintine. |
| 5 or 6 yards cotton batting. | Assorted sizes of splint |
| 5 or 6 feet ¼-in. galvan- | wood. |
| ized wire mesh. | |

In addition to the above articles there are, of course, plaster basins, large spoons, large refuse can, chair, leg rest, etc. The hospital stores should contain an adequate amount of replacement supplies, special splints and material likely to be needed.

MICHIGAN NURSES, ATTENTION!

In order that all non-registered, graduate nurses of Michigan may have the opportunity to register prior to December 1, 1921, another state board examination will be held in Lansing, Mich., December 6 and 7. All applications for this examination filed in the office of the board prior to December 1, 1921, will be considered under the term of the old law. All applications received after December 1, 1921, must qualify to ninth grade preliminary education and pay a fee of \$15.00.

Applications will also be considered for the December examination from candidates who have been graduated from schools not yet approved by the board of registration of nurses.

Under the provisions of the new law, all nurses who have obtained Michigan registration, whether by reciprocity or by examination, should apply for a new certificate, which may be obtained without examination and by paying a fee of \$1.00. Notification to this effect has been mailed to all nurses who have obtained Michigan registration either under the waiver, or by examination, or by reciprocity, during the period from 1909 to December 1, 1921; but, due to change of residence and probably other reasons, over 50 per cent of the letters have been returned to the office of the board.

All nurses practicing in Michigan and registered in other States, Canada, Great Britain, Ireland and other foreign countries are requested to write to the office of the board for a copy of the law, and are urged to file applications for Michigan registration before December 1, 1921.

CELEBRATE RILEY'S BIRTHDAY ON HOSPITAL SITE

The fact of unfavorable weather did not dampen the ardor of the hundreds of school children and many other persons who assembled on October 7, to take part in the celebrations of the anniversary of the birth of James Whitcomb Riley at the Riley homestead. This is to be the site of the Riley Hospital. The program which was under the auspices of the James Whitcomb Riley Memorial Association was made up of Riley poems and songs recited and sung by the school children and addresses by several speakers, including Dr. Charles P. Emerson, dean of the Indiana school of medicine, and Governor McCray.

The governor pointed out that Riley's love of children as shown by his many poems written for them, made the establishment of a hospital for children an especially fitting memorial. At the close of the program which was held indoors because of rain, the governor planted a tree on the site of the proposed hospital.

SCIENCE IN THE HOSPITAL LAUNDRY

BY WALTER TRIMBLE, CHICAGO

AS NEARLY every manager of a hospital laundry is in a fine position to have himself checked up by a scientist at frequent intervals, I wonder why so few take advantage of the opportunity. Nearly every hospital has a chemical and bacteriological laboratory in which many necessary tests could be made. As far as the chemical tests are concerned, any intern or drug clerk can make them with the apparatus which he will have at hand.

"Should one wash flat work and clothes in a washing machine that is used in washing pus-gauze or other infected material?" The foregoing question is one that was asked not long ago in the convention of an association of hospital managers, and, to my great astonishment, it was passed by without an answer being given, although several members indicated that they were anxious to get information on the subject, as it seemed to them to be an important one. I was astonished that the problem should be carried to the convention for solution by some of these superintendents, because

I knew that they were connected with large hospitals that had bacteriological laboratories, with scientists in them who could quickly, by means of actual tests, give a correct answer to the query.

Any hospital manager who wants a correct answer to this question should send to the bacteriologist a supply of the gauze that has been washed, taking it direct from the extractor, and have it tested. If it proves that the gauze came out of the washing machine in a sterile condition, it seems safe to assume that the inside of the washing machine also was sterile. That is, one would naturally assume that a process that would sterilize the goods would also sterilize the machine.

But it is never safe to assume anything in a hospital process, so go a little further in the mat-

ter, in order to be sure. Scrape from the inside of the outer shell of the washing machine some of the soapy deposit which is likely to be found there in greater or less quantity. Take this material to the bacteriologist also, and have him see whether it is sterile.

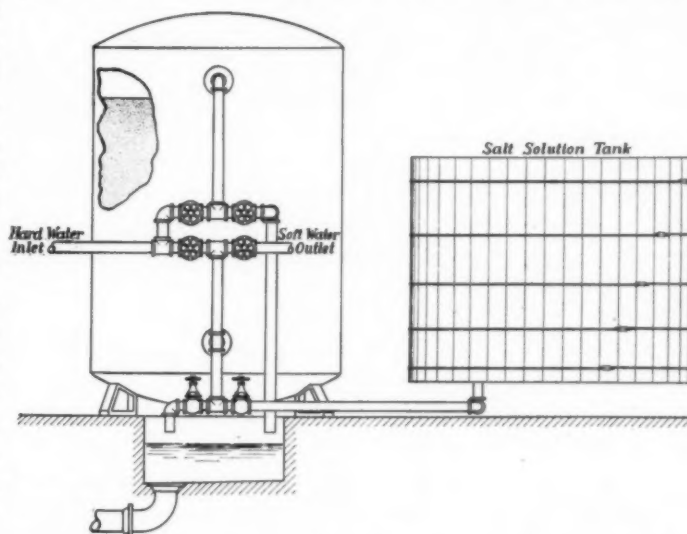
In all likelihood, the deposit will be as sterile as the goods washed, for both have been subjected to the same degree of heat. Nevertheless, this slimy deposit should not be on the inside of a washing machine, and steps should be taken to remove it in case it is there. This can be done by the use of a hot acetic acid bath or two, followed by a hot rinse. Where soft water is used, this scum, which is insoluble lime soap, does not form.

If the head washman is required to take a few samples each day of the water used in his last rinses, and if these are tested in the chemical laboratory, it will be pretty sure to reduce the hospital's expense for fabrics. The tests are so simple that even a drug clerk can make them, and no special apparatus is necessary.

For instance, where no "sour" is

used there may be left in the goods enough alkali to do considerable harm, because of insufficient rinsing. Where a "sour" is used to neutralize the alkali, a test of the rinse water may show that the acid is not being rinsed out thoroughly, and this may mean that holes will appear in the goods.

In case the "sour" consists of a solution of oxalic acid, if it is not rinsed out thoroughly, it will concentrate as the fabrics dry, and this concentrated oxalic acid will eat small holes in the goods. If some of your sheets or other articles come out looking as though they had been perforated with shot this is the probable cause. In one way oxalic acid is an ideal "sour," for it removes iron rust and has what washmen call "a tendency to brighten up the goods." But as it will not evaporate with the water, it must be rinsed out thoroughly. On the other hand, acetic acid will not remove iron rust, but it will evaporate



Standard zeolite water softening apparatus, as ordinarily installed in hospitals.

*This is the twelfth of a series of articles by Mr. Trimble on the hospital laundry, which is appearing in THE MODERN HOSPITAL.

with the water, and therefore there is no danger that it will concentrate and eat holes in the goods.

There should be tests of the rinse water that follows the bleach bath, to see that all the bleach is removed, and there even should be occasional tests of the blueing baths, for these may show either too much alkalinity or too much acidity. If your head washman is the right kind of a man, he will cooperate with you and profit by these tests.

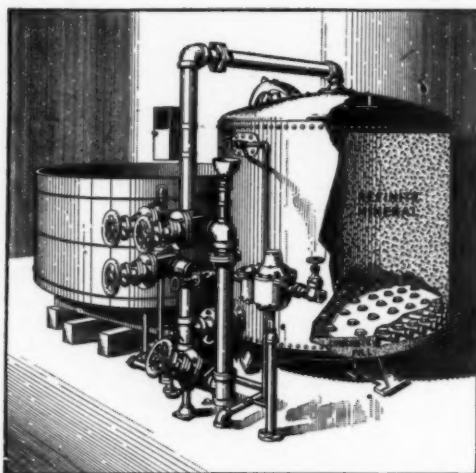
A few tests a day are not much trouble, they cost practically nothing and have a tendency to cause the washroom employees to pay strict attention to business and follow their formulas, especially if they do not know when some person will drop in and take samples of the water used in final rinses. I know of one instance where the adoption of this plan reduced an institution's expense for fabrics a substantial sum, and at the same time it reduced its bill for laundry supplies and secured a better grade of work.

As I have said before, if the hospital laundry manager will get acquainted with the chemist in his institution and get him interested, much good will come from this cooperation. There are many other ways than those I have mentioned in which the chemist, or even the pharmacist, can help the manager of a hospital laundry, such as the testing of bleach, soap, soda, acids and so forth, but I think that I have told enough to make it clear that the scientist should be consulted and his technical knowledge used.

Water Softening

In the July number of *THE MODERN HOSPITAL*, when I told of the advantages of using soft water I used the word "zeolite" several times, taking it for granted that all would understand its meaning. But as some readers seem to be confused in the matter, I will explain what it means in connection with water softening.

In the latest systems of water softening the

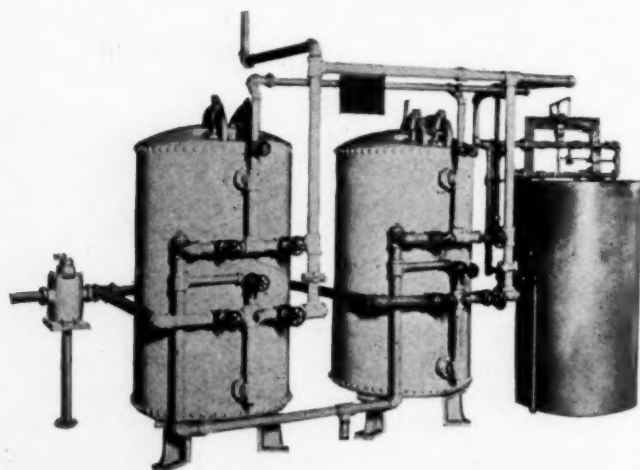


Industrial Model of Water Softener.

water is filtered, usually under city pressure, through a bed of small particles of a mineral compound, the chemical name of which is zeolite. This mineral is not always referred to as zeolite, however, as each concern that makes a zeolite water softener has its own trade name for its softening substance. Three of the zeolite softeners are made by companies which incorporate the name of their softening agent in the name of their business. The zeolite may either be compounded or taken from a natural deposit. In composition it is analogous to the feldspars, their chief metals being aluminum, sodium, potassium, and calcium.

A quantity of particles of zeolite are placed in the filtering chamber of the water softener, and as the hard water flows through in a continuous stream it has all of its "hardness" (calcium, magnesium, and so forth) removed. As I have stated, each maker calls this zeolite by his own trade name. Harmless salts of sodium or magnesium, or both, are formed as the hard water passes through the zeolite, an instantaneous exchange taking place. This is a chemical exchange, not a reaction.

When the zeolite has neared its "exchange limit," or the point at which the water ceases to come out at "zero hardness," it is regenerated or brought back to its original state by a very simple process, which is the passing through it of a solution of common salt. When the salt solution is run through the zeolite, the reverse of the softening process takes place. That is, sodium replaces the destructive minerals, they are discharged into the sewer, and the zeolite bed is again ready for work. Practically no zeolite is lost through this action, so the only expense involved is the small amount that must be expended for salt. It is only necessary to regenerate the zeolite once each working day if a softener of proper capacity is installed.



A two-unit Water Softener and automatic brine tank, arranged for twenty-four-hour irregular but continuous demand for soft water.

A SANATORIUM FOR THE WELL-TO-DO

BY EDWARD F. STEVENS, OF STEVENS AND LEE, ARCHITECTS, BOSTON AND TORONTO

PUBLIC sanatoriums designed for the treatment of tuberculosis of the masses are scattered throughout the country, and are supported by the state, the county, or the city; but private sanatoriums to furnish the same care for the well-to-do are less numerous and, like many private hospitals, some are being conducted in adapted private residences, giving splendid care but not planned to take advantage of all sunlight and air and freedom from noisy features.

One solution of such a problem is presented by the plans shown of the original development of the Central New England Sanatorium, an institution designed for the care of the better class of patients, where the home life is manifest—where each patient will have not only his own private room but his

to afford cottage sites and future extensions.

The administrative offices are placed in the north pavilion of the center portion, leaving an unbroken south front for sunlight and air. The lounge and dining room, extending through two stories, occupy the front of the center of the



Front elevation.



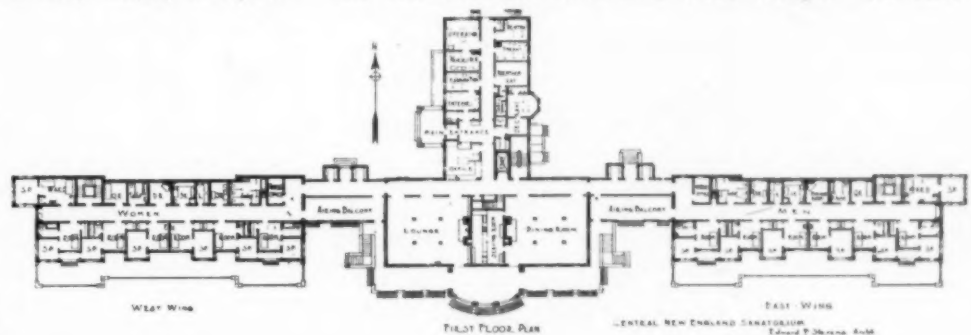
Ground floor plan.

private balcony, as well; and where the lounge and the dining room are not only large, but palatial, with fireplaces and gallery.

The site selected for this sanatorium is on the southern slope of one of the many hills of Massachusetts, in its highest and most central town, Rutland, and is approached by winding well-graded roads. The land is sub-divided

building, while the east and west wings are divided into patients' rooms and balconies on the south, and utilities on the north. On the first and second stories a private sleeping porch connects with each patient's room, and there are private baths for a majority of the rooms. A private dining room, serving kitchen, nurses' office, and other utilities are provided on each story.

The contour of the land is such as to allow for an additional story at the front of the east and west wings. On this



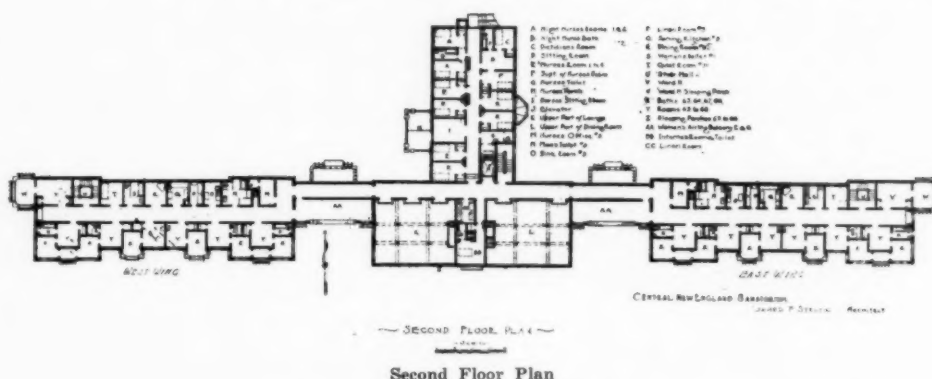
First floor plan.

floor there are thirteen private rooms, with a common sleeping porch. The grade also permits of a light and sunny kitchen in the front of the central pavilion.

Covered and uncovered porches extend the entire south front. Even the servants' quarters have ample sun porches.

The second story of the north pavilion will serve as a nurses' home. On the third floor are guest rooms for friends of the patients, a portion of this story being used for servants' rooms, while the front of the central portion is planned for the use of the superintendent and his family.

If completed and carried out as planned, this



Second Floor Plan

JOHNS HOPKINS LOSES DR. K. H. VAN NORMAN

Dr. Karl H. Van Norman, first assistant director on the administrative staff of the Johns Hopkins Hospital has resigned his position to accept the directorship of the new Miller Hospital of St. Paul, Minn. It is a splendid opportunity, and a great compliment to Dr. Van Norman in having been selected for this post.

The Miller Hospital was completed and occupied about a year ago. It cost over a million dollars; it has a capacity of 225 beds, and a large children's department is still to be added, also a large outpatient department for the treatment of the ambulatory sick. This hospital will probably be used in connection with the University of Minnesota for postgraduate teaching. Dr. Van Norman is to take up his new duties as soon as Dr. Smith can make

arrangements to relieve him at the Johns Hopkins Hospital.

Dr. Smith states that Dr. Van Norman has received several offers from other cities, and that he has realized for some time that it would be impossible to retain his services here indefinitely, but that Dr. Van Norman's going will nevertheless represent a distinct loss to him and to the hospital. Dr. Van Norman came to the Johns Hopkins Hospital in January, 1913, as an assistant superintendent. After the death of Dr. Rupert Norton he was made first assistant, which position he held until November, 1915, at which time he resigned to enter the service of the Canadian Army Medical Corps. He served in the Canadian Army for four and a half years, receiving various important assignments along the lines of administrative work in connection with the Canadian war hospitals. When Dr. Ralph B. Seem left in May, 1920, to accept the directorship of the Albert Billings Memorial Hospital for the University of Chicago, Dr. Van Norman returned and again took up his duties as assistant director at the Johns Hopkins Hospital, which position he has held since that time. Dr. Smith is unable to state at this time who his successor will be.

DR. SMITH HAS NEW ASSISTANT

Dr. Herman Smith, superintendent of the Michael Reese Hospital, Chicago, has a new assistant, Mr. L. C. Austin, who took up his duties on October 1.



Third Floor Plan

sanatorium, with its cottages, camp, and workshop, will make a most ideal center for the care of tuberculosis.

The institution is of tile construction, with cement stucco plaster finish.

SUPERINTENDENT VISITS HIGH SCHOOLS TO EXPLAIN NURSING

The following plan for recruiting pupil nurses has been used with great success by Miss Marie Louis, superintendent of the Muhlenberg Hospital, Plainfield, N. J.:

Just before the closing of the high schools of New Jersey, Miss Louis visits the high schools in a number of the nearby towns in company with from two to six of her senior nurses. She gets the permission of the principal to give a talk to the graduating class at the chapel exercises, at which time the several student nurses accompanying her also speak to the senior class explaining the high calling of the nursing profession and the advantages for training offered at the Muhlenberg Hospital. Miss Louis also obtains from the principals of the several schools lists of the graduating classes with their home addresses, and personal visits are made, followed up by a series of several letters to the girls at their homes during the summer. The result is that she always has her full quota of probationers and has an exceptionally good type of applicants from which to select.

THE NURSES' DORMITORY BUILDING AT KINGSTON, NEW YORK

BY GEORGE E. LOWE, ARCHITECT, KINGSTON, N. Y.

THE nurses' dormitory building for our Lady of Victory Sanatorium is situated upon a plot of ground having a continual rise in grade, from the street adjacent to the lower end of the building, until it meets the level grade, a distance of approximately ninety feet. In placing the dormitory upon the site, the governing factors were the nearness to the hospital building, the outlook, and the grade above described. The plot is very hilly and rocky, and is situated on the outskirts of the city, away from noise.

The building is so placed on the site that an extension to the present hospital is made possible without any interference with the nurses' dormitory, and after this addition is built, the dormitory will be within thirty-five feet of the hospital proper.

The site commands a view of the city and the picturesque Catskill mountains in the distance.

One enters through a vestibule, the main hall, which contains the main stairway. The floor and base of the hall is of composition, as also are the treads and platforms of the stairs; the stairs are built entirely of iron and composition with a small wood hand railing.

The side walls and ceilings of the hall are of plaster, finished at the base with a painted burlap wainscot, and at the angles of the side wall and ceiling with a wood cornice. The panel in the ceiling opposite corridors is formed with wood beams supported at ends upon wood pilasters, this treatment giving distinction to the doors which lead to the living and sleeping apartments, adjoining the main hall on this floor.

The floors and base are of tan color composition, the burlap wainscot is painted a slightly lighter color, while the walls above the wainscot are of buff. The cornices, pilasters, and other woodwork in the hall are natural Tennessee chestnut, finished brown color; the ceiling panels are of ivory white. All the doors leading from the hall to corridors are glazed and divided with wood

muntins. Doors to sleeping apartments are translucent glass; others transparent.

It can readily be realized that this main hall, its disposition of entrances, and its general color scheme, can only give a reception of welcome and a homelike atmosphere, which necessarily should exist in a home of this character.

A large living room, with beam ceiling, painted burlap wainscot, tapestry brick fireplace, with tile hearth, and having hardwood floor, is located at one end of the building and entered from the main hall through a passage which separates the remainder of the living apartments from the living room. The remainder of the living apartment is composed of a library and reception room,

containing bookcases, and a classroom which contains a white enameled sink, electric range, cupboards necessary for dishes, etc., a refrigerator with connected waste to sewer, a closet for supplies and paraphernalia used during class work. The floor of the classroom is of composition. A folding partition separates the classroom from the living room, this feature being incorporated in the plan so that the end



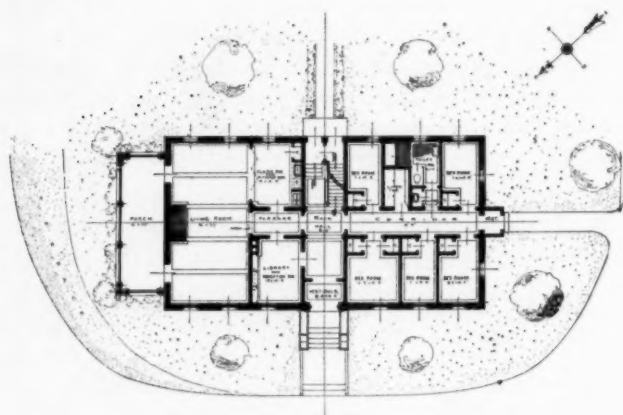
Nurses' dormitory building, Our Lady of Victory Sanatorium, Kingston, N. Y.

of the living room can be utilized together with the classroom, for class work, thus eliminating the necessity of a large classroom. Of course, the reason for a large living room is the fact that it can be used by house parties, otherwise a smaller living room would meet all the requirements. When a house party is being given, a buffet luncheon can be prepared and served from the classroom, which is equipped for such purposes. Adjoining the living room is a private porch running practically the full length of the building which is ten feet in width, it being reached through French casement windows from the living room. The sleeping apartments on the first floor are separated from the living apartments by the main hall.

A bathroom with ceramic tile floor, base, and wainscot, with all bathroom accessories, porcelain

lavatory and closet with flushing valve, is provided on this floor, as is also a linen closet with sanitary composition flooring and a janitor's sanitary sink. The center ceiling light in the closet is operated by a jamb switch when the door is open, and automatically turned off when the door is closed.

There are eight bedrooms in the building, accommodating one nurse each, and four accommodating two nurses each, taking care of a total of sixteen pupil nurses. Each of these bedrooms



Plan of the first floor, nurses' dormitory building.

contains separate closets for each nurse, complete with shelving and rod for coat hangers. The trunks are kept in a trunk room in the basement, directly under the living room. The night nurses have been provided with separate rooms with connecting bath, having ceramic tile flooring base and wainscoting with built-in tub, accessories, and beveled plate mirror the full height of the door.

On the second floor the bath room is separated from the toilet room. The bath contains built-in tubs, porcelain lavatories, and all bathroom accessories, and the tubs are placed in separate compartments whose partitions are elevated above the floors and separated from the main room by a tile curbing. The closet door between the two baths has a mirror of full height, and the closet is used for access to the plumbing for the tubs, and also for a storeroom for bath supplies.

Overhead showers are provided over each of the bath tubs, with mixing valves which control the temperature of the water.

The toilet room has a composition floor and a wainscoting on the side walls of "Keenes" cement marked off in imitation tile.

The second floor is also provided with a linen closet, and a janitor's sanitary closet is provided for on the first floor. At the end of the second story corridor, over the porch of the first story, will be found a balcony for the use of the nurses

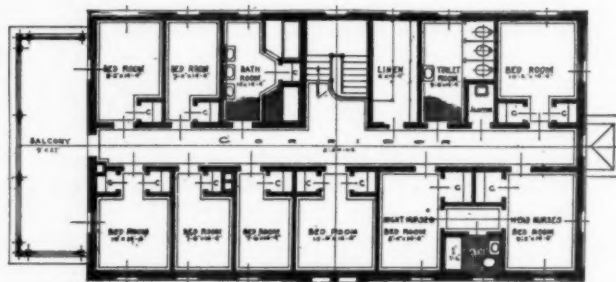
on the second floor. The floors of the corridors are of composition flooring, with base, and a painted burlap wainscoting is placed on side walls. At the right of the building is the first story corridor, in an entry which gives access from the hospital building to the nurses' dormitory, and as mentioned before, is about thirty-five feet distant from the new addition which will be shortly erected.

The exterior walls of the building are faced with selected hard burned North River brick, laid in pattern, and in red colored mortar, with tooled joints. The trim is of cast artificial stone. The general exterior treatment harmonizes with the present hospital building.

All corridor and stair enclosure walls are of masonry construction, as well as all exterior walls, with direct plastering, no furring. Exterior walls are backed up with hollow tile. All other interior partitions are of frame, and the floor and roof construction is of frame. The roofing is of fire-proof material and all roof water is drained through interior drains.

The building is equipped with a modern heating system with graduated valves on the radiators controlling the heat in the several rooms. An advantage with this system in the dormitory building is that the windows may be left up in cold weather without any possibility of freezing and cracking the casting.

All interior trim is of Tennessee chestnut, and there is no trim placed on any of the window openings of exterior walls, or on the corridor side of doors, as plaster reveals are placed at these window and door openings. Each room has a central electric light fixture controlled by switch,



Plan of the second floor, nurses' dormitory building.

and a base receptacle outlet for table reading lamp, which also may be used for electric vacuum cleaner.

The ceiling fixtures of the bedrooms are of the indirect type and in the living room are of the standing candle, pan type, suspended by center chain; all of Flemish brass finish.

The hot water for the several fixtures in the building is supplied from a hot water storage

tank and heater in the boiler room and basement. The plumbing system is of the best, well ventilated, and having all modern fittings. The reason for the flat roof construction of this building is that if there were an attic over the second story, it would be a catch-all and a fire trap, and if it were converted in time into sleeping apartments, it would necessitate the erection of fire escapes, as required by the state law, and this would mar the appearance of the building.

Registers are placed in the ceiling of the second story corridor directly under the ventilators in the roof for ventilating the attic space, and also the corridors.

The building, inclusive of porches contains 75,000 cubic feet, and the cost is approximately fifty cents per cubic foot, making a total of \$38,000. The building is thirty-five by sixty-five feet with ceiling heights of nine feet.

HEALTH FORTNIGHT MARKS PUBLIC HEALTH MEETING

The fiftieth annual meeting of the American Public Health Association will be the occasion of a Health Fortnight. From November 8-19, New York City will be the scene of activities connected with this event, and the publicity, with its slogan "Health First," will stimulate interest throughout the country.

Health Fortnight will include three major divisions—a Health Institute from November 8-11; a Health Exposition, November 14-19; the Fiftieth Annual Meeting of the American Public Health Association, November 14-19. Representatives from virtually every state in the Union and from many foreign countries will participate in the extensive program.

To focus the attention of the general public upon this celebration, November 13 will be observed as Health Sunday in many churches. Health Day will also be observed in the synagogues and in numerous business and social organizations. Speakers prepared to talk authoritatively on health topics will be furnished on request to any of these organizations. The New York County Chapter of the American Red Cross is cooperating with the general committee in the arrangement for this service.

The Public Health Exposition will undoubtedly make the widest appeal to the lay public. It will be the largest affair of its kind ever held in New York City. It will be conducted under the joint auspices of the Department of Health of the City of New York and the American Public Health Association. Already allotments of space indicate that at least two entire floors of the Grand Central Palace will be occupied by exhibitors. The exhibits will include those of educational and philanthropic organizations and those of commercial houses producing approved articles of health value.

Every legitimate means will be utilized to promote attendance at the exposition, for this will be the most effective way in which the message of Health Fortnight may be brought to the public. The fact that a similar health exposition held in Chicago a year ago drew an attendance of over one hundred thousand indicates the extent to which this form of popular education may be carried. Naturally, in New York, with its larger population, a proportionately greater attendance is expected

at the exposition. The profits from the sale of tickets, after the cost of the exposition and the convention is defrayed, will be devoted to establishing nutritional clinics for the benefit of undernourished children. In this connection, Dr. Royal S. Copeland, health commissioner of the City of New York, will present a series of educational exhibits in which instruction in the feeding of children will be featured. Dr. Copeland is chairman of the exposition; A. W. Hedrich of the American Public Health Association is secretary, and Dr. C. E. North, treasurer and general manager.

The Health Institute from November 8-11, will present to visitors to the convention an unusual opportunity to see the operations of established methods applied to various phases of public health work. About forty demonstrations have been planned.

Following the week of the Institute and the observance of Health Sunday, will come the opening of the scientific sessions, the meetings of the American Public Health Association in celebration of its semi-centennial. The sessions will begin on November 14 and the headquarters will be at the Hotel Astor, Broadway and Forty-fourth Street.

The founder of the American Public Health Association, Dr. Stephen Smith, although in his ninety-ninth year, is still active and will participate in the meeting. A banquet will be held in Dr. Smith's honor as a part of the semi-centennial celebration.

As a permanent souvenir of the semi-centennial and as a record of the work accomplished, a Jubilee Historical Volume entitled, "Fifty Years of Public Health," will be ready for distribution during Health Fortnight. Although, as the title indicates, the book concentrates on progress made in the last half century, it also traces the public health movement from its early beginning. Further information regarding the semi-centennial may be obtained from the American Public Health Association, 370 Seventh Avenue, New York City.

PUBLIC HEALTH SERVICE TO HOLD TWENTY-FOUR INSTITUTES

In response to a preliminary announcement of the Public Health Institute, which the Public Health Service had planned to hold in Washington this fall (but which has been postponed indefinitely), a large number of city and county health officers, physicians, nurses and others replied indicating a definite intention or hope of attending.

The Public Health Service felt that it could not ignore this widespread interest in institute work, and after correspondence with the various state boards of health, decided to hold a series of twenty-four institutes at various population centers throughout the country.

It is expected that most of the well known specialists announced for the two weeks' institute in Washington will be on the faculties of two or more of the various local institutes. No tuition will be charged.

The centers will include such widely separated points as Chicago, San Francisco, Hot Springs, and Washington. The schedule of courses, which will probably be adopted with some alterations by the various institutes, includes the following subjects: syphilis, tuberculosis, nutrition in health and disease, the delinquent, the general communicable diseases, child hygiene, industrial hygiene, and sanitary engineering.

The board of trustees of the county hospital at Hartford, Ind., has been receiving bids for an \$80,000 building, to be of brick, two stories and basement.

THE ADMITTING AND EMERGENCY UNIT OF THE NEW YORK HOSPITAL

By JOHN A. COLUCCI, M.D., ADMITTING PHYSICIAN OF THE NEW YORK HOSPITAL, NEW YORK CITY

THE admitting and emergency unit of the modern hospital is now generally recognized as one of the most important departments, if not the most important, in the large general hospital. Here all cases are received no matter what the character; here, too, the diagnosis must be made and the first treatment administered. It is comparable to the sampling room of a factory, the registration desk of a hotel, or the information bureau in one of the railroad terminals. The centralization of authority and the concentration of emergency facilities are chief factors in the building up and equipment of an admitting and emergency unit. It is because this centralization and concentration have reached such a high state of perfection at the New York Hospital that this article is written and this system highly recommended.

Old Department Unsatisfactory

This department of the hospital under the old plan of organization proved to be entirely un-

clerical, while upon the emergency unit rested the responsibility of treating the accident cases. The ambulance surgeons and surgical juniors constituted the emergency unit and were subject to call according to the following arrangement:

Monday, Tuesday and Saturday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Third Ambulance Surgeon, to 6 p.m.

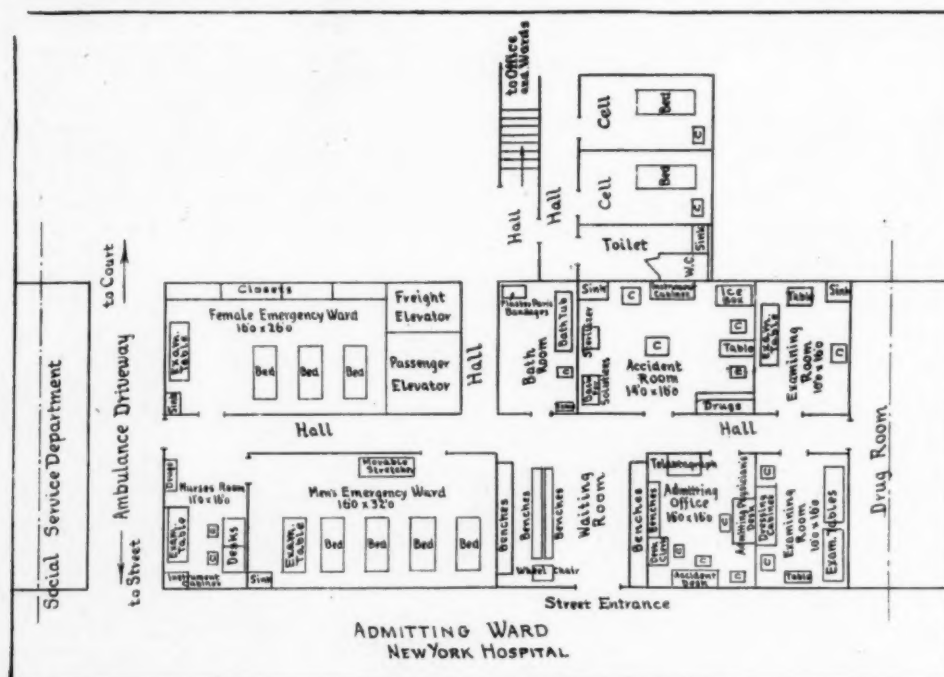
Third call for dressing cases: Until 6 p.m. Surgical Junior takes second call for dressing cases.

Wednesday, Thursday and Friday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Third Ambulance Surgeon, to 3 p.m.

Third call for dressing cases: Until 3 p.m. Surgical Junior. After 3 p.m. Surgical Junior takes second call for dressing cases. No third call after 3 p.m.



Floor plan of the admitting and emergency unit of the New York Hospital.

satisfactory. Nothing short of complete reorganization could remedy its many defects. The admitting and emergency departments were practically two distinct units. The functions of the former were chiefly administrative, financial, and

Sunday

First call for dressing cases: First Ambulance Surgeon.

Second call for dressing cases: Surgical Junior. No third call for dressing cases.

All medical-treatment cases were treated by the medical second senior on ambulance duty.

Old Procedure Necessitated Delays

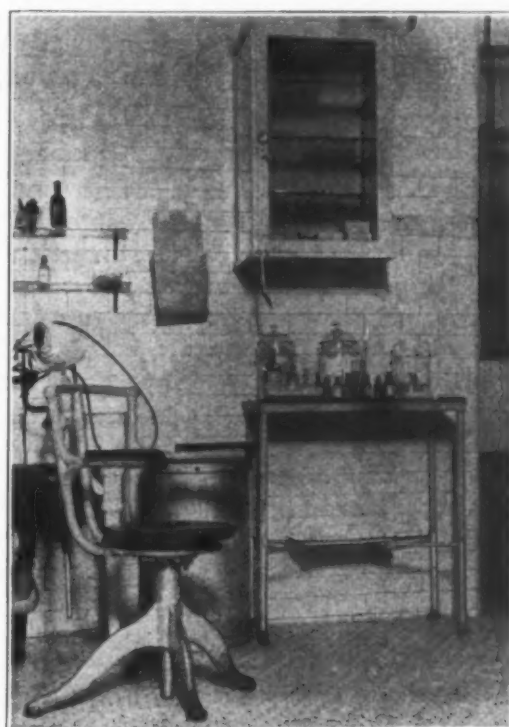
Upon arrival of an accident case at the hospital the nurse in charge of the emergency ward notified the intern who was subject to call. Such a procedure not infrequently involved considerable delay in the treatment of such cases. Ward duties too often occupied the attention of the nurses and interns; delay in the conveyance of messages and difficulty in locating the interns, at times, were partly responsible for the inefficiency of this department. But, that which was most conducive to this inefficiency was the fact that the ambulance surgeon's time in the accident room was frequently interrupted by ambulance calls. For instance, during the year 1920 there were 5,853 ambulance calls, averaging sixteen per day and varying from a few to as many as thirty-seven calls in a day. Needless to say, the efficiency of this department, based on such a scheme, bore a definite relation to the type of intern. Much depended upon his personal qualities. While it is true that the present plan deprives the intern of the experience that can be derived from the accident department, it is true only in an official sense. He is not denied the privilege of treating accident cases under the guidance of an experienced admitting physician. On the other hand, the interns are encouraged to spend their spare moments in the accident room and are permitted to choose and treat what cases may prove of interest to them.

Present Plan Eliminates Delays

Avoidance of delay, therefore, in the treatment of emergency accident cases, constituted the main object in the development of the present plan of organization. Ordinarily, the extent of most injuries are, in the eyes of a physician, very trivial; but, to the patients, they are often a source of grave apprehension, and where delay in the treatment thereof is unduly prolonged, the good name of the hospital and its constituents suffer, frequently being subjected to severe criticism. That this defect in the emergency department might be remedied as completely as possible, it is evident that a physician must needs be in constant attendance in the accident room, so that the accident cases may be given immediate attention. It was therefore deemed advisable to have the admitting physicians treat the emergency accident cases, thereby combining the admitting and emergency departments into one unit.

Three salaried admitting physicians are employed, each on duty five and one-half hours a day, and in all, covering a continuous period from

7 a.m. to 11:30 p.m. Only young, energetic, and practicing physicians are accepted for such a task. Under the old plan, the admitting physician was burdened with all the clerical work necessary for the admission of cases to the hospital, together with innumerable other minor office duties, all of which could easily be entrusted to an efficient clerk. That his time, therefore, might be devoted entirely to the examination of patients applying for admission to the hospital and the treatment of all emergency and accident cases, a clerk was added to the personnel of this department. Ex-



The treatment room is fitted with all necessary facilities for treatment.

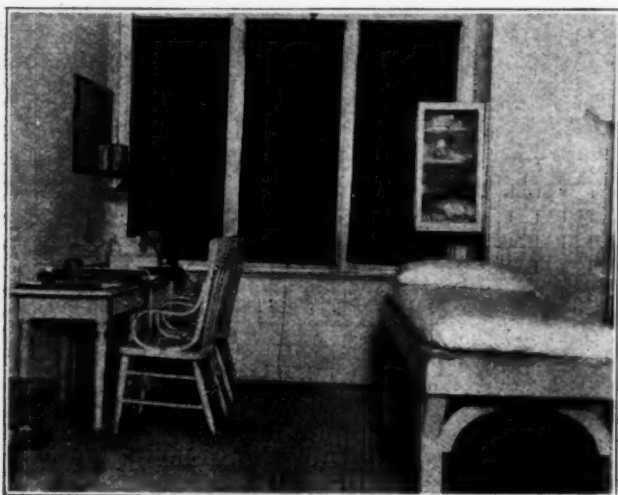
perience has proved this to be a very happy and fruitful arrangement, and, with the assistance of a nurse and orderly, puts this department on a very practical basis.

In order that the working efficiency of this newly organized department should approach the point of perfection, it was found necessary to rearrange the setting of the rooms comprising this department, the essential being economy in time and labor. The accompanying plan shows in detail the composition of this department of the hospital, and, as will be seen, the necessary advantage in concentrating its various activities over a small area. Originally, the social service department carried on its activities where the admitting office is indicated on the accompanying sketch, the admitting department in the waiting room and the accident department in the social service room. In our experience, such an

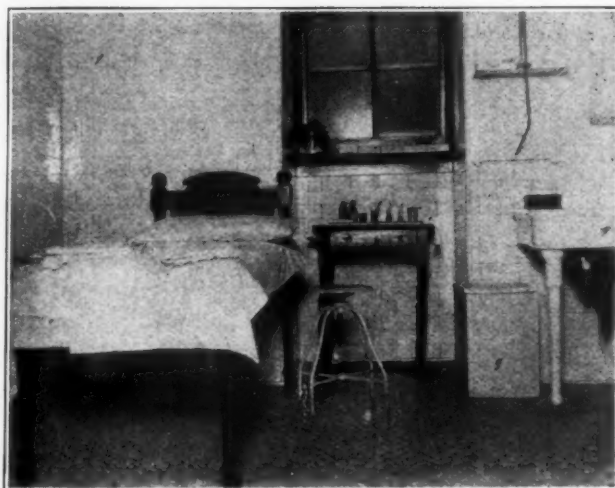
arrangement proved entirely unsatisfactory, the greatest disadvantage being in the unavoidable waste of time, in that the admitting physician was forced to treat the accident cases at the one end, and examine cases for admission at the other end of the floor. Besides its great advantage in the economy of time and labor, the present scheme allows all the activities of this department to be under the immediate control of the admitting physician. Here he has all the patients before him and can arrange his work according to the degree of emergency in each case. He is ever present to receive all cases that are referred to the hospital for admission or treatment, and does not have to depend upon being notified of the arrival of any patient by the nurse or orderly, as was necessary under the old plan.

Department Now On First Floor

This department is located on the ground floor and the entrance to it leads directly into the waiting room, which is in immediate connection with the admitting office, the accident and examining rooms. Ambulatory accident cases are escorted directly into the accident room, treated, and then referred to the admitting office to interview the clerk, who, after obtaining the patient's pedigree, gives him a dispensary card and the necessary instructions. The history of the case is entered in a yearly record book and also on a history blank, the latter being sent to the dispensary the following morning, where the future course of such accident cases is followed. Non-ambulatory cases, whether accident or ordinary medical and surgical, enter through the ambulance driveway and, with the assistance of the nurse or orderly, are prepared for examination either in the emergency wards or the examining rooms, depending upon circumstances. In all, there are six examin-



There are six examination tables conveniently arranged and not too numerous in the emergencies which sometimes arise. At the right of the picture is one of these tables, and at the left is shown a nurse's desk.



Non-ambulant patients are prepared for examination either in the emergency wards or in an examination room, one of which is shown here.

ing tables conveniently arranged to meet all purposes and not at all too numerous in times of emergency like the Triangle Shirt Waist Company fire and the recent Wall Street explosion. Cases suggesting the necessity of an immediate operation are referred at once to the house surgeon, who, in turn, after recording the physical findings and the necessary laboratory data, reports to his attending surgeon, upon whom rests the responsibility of deciding whether or not the cases need immediate operation. The disposition of all cases applying for admission is in the control of the admitting physician, subject, of course, to certain rules and regulations. In the case of children, as a means of precaution, nose and throat cultures, the Shick test, and, in the case of female children, a vaginal smear, are taken before they are admitted to the wards. Any patient, whether child or adult, with any suspicion of a contagious disease, is referred to the proper hospital. Here, in this connection, it is well to point out the importance of a bathroom in the admitting department. All patients, except the very sick and the women, are obliged to take a bath, and have their clothes and valuables listed with the orderly or nurse, before they are admitted to the wards. Cleanliness, of course, is the main object, but frequently it reveals many objectionable skin and venereal diseases.

Disposition of Cases Convenient

The detail arrangement of the admitting and emergency department is sufficiently indicated in the accompanying sketch, necessitating no special comment, except that they have been so arranged to permit of the most convenient and most rapid disposal of the cases. The accident room is so fitted as to afford every facility for the treatment of all minor surgical accident and emergency

cases, including fractures. With fracture cases, of special importance are the facilities of the x-ray department, situated on the next floor, where, with the aid of the fluoroscopic x-ray machine, exceptionally good results in their reduction can be obtained. It also helps in establishing a correct and immediate diagnosis.

A word about the amount of activity of this department of the hospital will not be amiss. During the year 1920, six hundred fractures were treated, while the ordinary dressing cases and minor operations numbered 6,750, averaging

twenty cases a day. In the same year, 5,944 patients were admitted to the wards of the hospital. These figures, together with the other activities of this department, indicate roughly the amount of work accomplished by the department and the important position it holds in the hospital. Indeed, it is safe to say that it is unquestionably the most responsible department of the hospital as it covers a multitude of activities, administrative, financial, clerical, medical, and surgical, which are of vital importance to a busy modern hospital.

COUNTRY CONVALESCENT INSTITUTIONS FOR HEART DISEASE*

BY FREDERIC BRUSH, M.D., MEDICAL DIRECTOR, THE BURKE FOUNDATION, WHITE PLAINS, N. Y.

THE recuperation of the heart diseased in country institutions has advanced so rapidly in the past five years that certain approximate standards are forming. These are of value, especially to communities that are just beginning organized health effort in this branch. Progress has come through: (a) the gradual overcoming of the prohibitions against cardiacs in existing homes; (b) the establishment of special heart-convalescent places; (c) broadening and elaboration of function in the various homes, and (d) better cooperation in the selection, preparation, convalescent placing and occupational follow-up.

More uniformity and surety exists in the requirements for cardiacs than for the other classes of convalescents—the needs of the latter being more ameliorated by the living, recreational and standard health care conditions of each community. But heart patients cannot be hurried from the hospitals or their homes to get along fairly with average dispensary and private after-care; they need prolonged bed-treatment, and to be graded through country convalescence into environment and occupation suitable to each individual—or the equivalent via clinic and home direction. They require, furthermore, occasional *re-convalescent periods and preventive recuperations*. Thus heart care plans for one American city will fit others measurably well.

It is mainly this clear and stable need that is now causing heart convalescence to outgrow other kinds, proportionately.

In the recent health program for the city of Cleveland more than one-fifth of all proposed convalescent beds were given to heart disease; and in actual operation now in New York City nearly

one-sixth of such beds are for this condition. In an American city of one million population (a convenient planning unit) there are at least twenty thousand persons with heart disease. Experience so far points to a working estimate of from three to five per cent of these (six hundred to one thousand) in need of institutional convalescence in one year, bringing a requirement of from sixty to one hundred year-round beds (with average stay of five weeks). Adopting the one hundred bed requirement, the classification may be suggestively worked out by the allotment of thirty beds to adults and seventy to children from six to fifteen years old—arranged feasibly somewhat as follows:

1. Adults of both sexes to have entrance to thirty beds in one or more general convalescent homes where some special direction is afforded.
2. A separate institution receiving ten boys from six to ten years old, with twenty-five girls aged six to fifteen.
3. Fifteen older boys (ten to fifteen) to be



Cardiacs in a short-golf tournament on the slopes of the Heart-Cottage.

*Paper read before the College of Physicians of Philadelphia, May 4, 1921.

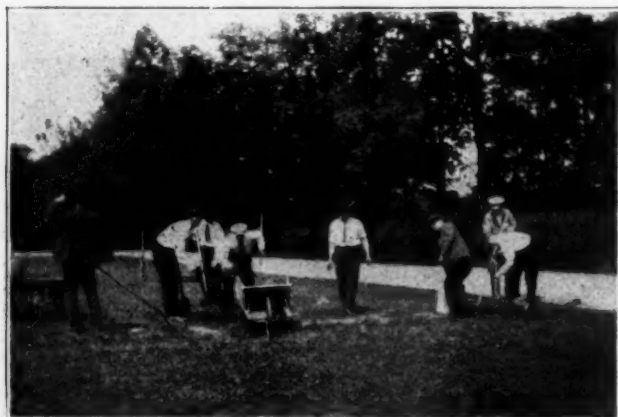
treated along with others in a general convalescent boys' home.

4. Twenty sicker children of both sexes and ages up to fifteen, and requiring considerable bed and reclining care at first, to have a specialized place.

This ratio would give New York City from five to six hundred beds for heart convalescence; and that this is not a fanciful or too ideal city plan is indicated by the rapid growth there to a present provision of over three hundred beds—with large extensions in prospect; five-sixths of these three hundred beds are for children, which is too high a proportion (note the two-thirds proposed above), for while childhood, and adolescence particularly, are the proven periods for best reconstructive and preventive results, it is recognized that more adult cardiacs, and especially men under forty-five, should have access to such homes.

Types of Homes and Functions

Heart convalescents in institutions require regulated rest, graduated exercise, mental readjustments generally, directed work and play-therapy, continuation schooling if young, some beginning vocational guidance, and end-linking with suitable occupation and years of follow-up. But all of these functions are coming to be demanded of our general convalescence, and are precisely adapted to it. It is a far step from the few older rest places and retreats to this new, essentially American convalescent health-plant with its active tonic and formative atmosphere; and every one of *these general homes* (children and adult) *should receive the properly selected and prepared heart convalescents*; and may be assured of safety and success with them. The mistaken idea that cardiacs will be endangered by too active association with other convalescents is giving way to the understanding that they tend rather to a faulty inertia and under exercise, and that they will grade almost automatically into the various up-building activities. The mental and habit effects



The patients laying a walk under supervision.



The heart patients find haying not too strenuous as an occupational exercise.

of this mixed grouping are most valuable, simulating everyday life—being prepared for it. We are probably in the stage of too much segregating of cardiacs. Certain special heart homes for children in the more seriously crippled classes are undoubtedly essential.

The importance of the country location with ample grounds can hardly be overestimated; it is the out-of-door rest, play, work, grade-walking, and the inspiring anti-neurotic general all-day activities that must make up the major portion of the restorative and heartening interests, compared with which indoor gymnastics can give but scant results.

Providing the Facilities

No one expects an ideal plan to be precisely realized in any community. Practically, first should come acceptance of the *idea that any scheme of cardiac care includes country convalescent outlets*. Next is the getting of heart patients accepted in the existing homes, and having them definitely planned for in those under development. Then will come means and sympathetic interest from many and often unexpected sources, to establish new places, for children especially; and each of these should be promptly accepted and fostered. Time and experience and the assured successes will mould them into varied appropriate functionings.

Certain facts kept to the fore aid in getting and extending these desired provisions: Institutional heart convalescence is as safe and manageable as other kinds, demands but little medical oversight, may be well done in mixed grouping or separately, requires no new or expensive buildings and equipment, and yields results of such high order and permanence as constantly to astonish its patrons. It is an essential in any community health scheme.

Costs are about one-half that of hospital care—

or from \$1.50 to \$2.00 per day per capita—requiring, e.g., from \$15,000 to \$20,000 per year to run thirty beds. There is little prospect of its overextension, for the broad *preventive phases* (including prevention of heart disease incidence and of diseased heart overstrain) are *mainly undeveloped*. Convalescent organizations and methods are now sufficiently standardized so that full information is readily available.

"Fresh-air" camping and various recreational outlets are contributing factors in the prevention and recuperation of heart disease. On the other side is the question of institutional provision for the more seriously crippled—the cardiac invalids; but this requires separate study, and is not here included in the convalescent problem, though bordering it closely and constantly interchanging with it.

RED CROSS CARRIES ON FAR-REACHING ACTIVITIES

Public health nursing and the establishment of health centers are the two chief activities by which the American Red Cross is developing its public health program. Health centers have met the great need for coordination of health agencies and the bringing of these agencies into closer contact with the local, state and national official agencies, and the great body of doctors of the country. Of the 503 centers in the United States reported to National Red Cross Headquarters up to September 1, 1921, Red Cross chapters support wholly or in part, 407. These centers have become health information centers, and in the first six months of the year 100,000 inquiries were carefully answered. They have been the means of a wide distribution of health literature prepared by experts in all phases of health. During the first six months of this year 270,000 pieces of health literature were distributed.

Red Cross chapters have met the need for clinics in hundreds of communities always in such a way that the field of the physician is not invaded, and that the community as a whole benefits. Mostly they are located in health centers, but sometimes they have been conducted as separate projects. During the first six months of the year nearly 5,000 clinics have been conducted.

The great need for health knowledge has been met in part by the organization of Health Lecture Courses, and during the first six months of the year nearly 15,000 have been provided by Red Cross chapters.

Many chapters are promoting health education by constructing and conducting health exhibits, the use of health moving pictures, the Health Clown, health playlets and health clubs. During these six months 700 health exhibits were held and more than 1,500 health club meetings conducted.

Plans for the future contemplate the extension of all these activities and the meeting of any other health need not being met by any other organization in the community. The Red Cross always works to the end that the work it is doing shall at the proper time be taken over by the official agency whose function it is eventually to do that work.

The public health nurses of the Red Cross, of whom 1,267 were employed by chapters in 1,240 different places on July 1, 1921, are at work in all parts of the country.

They are found in the high places of the Sierras, on the plains of New Mexico, the Indian reservations, among the negroes of the lowlands of the Gulf States, in the mountains of Kentucky and Tennessee, the forests of the Northern States, and on the lonely islands of the New England coast, as well as throughout the towns and villages of the country.

All this work, in addition to the First Aid and Disaster Relief Work and the Nutrition Service, is a part of the peace-time program of the Red Cross. Moreover, many of its war obligations are still unfulfilled. Most important of these is care of the disabled ex-service men. The Red Cross expenditures for the disabled men are running at the rate of \$10,000,000 a year. And the number of these men has not yet reached its peak. Through its Fifth Annual Roll Call, to be held November 11-24 of this year, the Red Cross hopes greatly to increase its membership in order that the work may be continued at a high level of efficiency.

TO STUDY HOSPITAL ADMINISTRATION


The Rockefeller Foundation desiring to promote medical education and public health on an international basis and believing that trained leadership is essential to sound progress provides fellowships to promising medical men from various countries. Eight physicians from Czechoslovakia and three from Poland have just arrived in New York for a period of research and study under such fellowships. The men have been selected on the basis of qualification to pursue advanced courses in preparation for institutional or government service later in their own countries, either as teachers, investigators or administrators. One of the physicians, Dr. Jan Surawski, of Poland, will make a special study of hospital administration and schools for training of bedside and public health nurses. Dr. Surawski is a graduate of the medical faculty of the University of Zurich. After practicing medicine for a period of years, he became a health officer and later a hospital inspector. At present he is assistant in the Bureau of Hospitals in the Polish Ministry of Health and will return to the Ministry of Health to take charge of the Divisions of Hospitals.

PLAN TO HAVE FOUR YEAR COURSE

A four year course in medicine is to be established at the University of Missouri, according to an announcement by the board of curators. The course has consisted of two years in the past, but it will be increased as soon as hospital facilities are available for clinical work. The legislature has appropriated \$250,000 for the establishment of a state hospital at Columbia for the purpose of providing the clinical material for the students. A similar sum will probably be appropriated at each session of the legislature until \$1,000,000 is available.

LIBRARY RECEIVES GIFTS

Three interesting books have recently been presented to the Hospital Library and Service Bureau. The third edition of "Notes on Hospitals," by Florence Nightingale, published in 1863, was presented by Mr. Richard E. Schmidt of Chicago. Mr. Daniel D. Test, superintendent of Pennsylvania Hospital, Philadelphia, Pa., sent the library a copy of the "History of the Pennsylvania Hospital from 1751-1895," and Dr. J. J. Dowling, superintendent of the Boston City Hospital, sent a copy of the "History of the Boston City Hospital from 1864-1904."



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HOSPITAL RULES AND REGULATIONS

THE rules and regulations of a hospital are not given the thought they deserve. Administrators are very prone to be governed by their own viewpoint and their own convenience and not to consult the patient or public.

Business men soon learn to conduct their stores and offices to meet the whims and desires of their customers. Trade goes to the place where, others things being equal, it is made easiest to trade. This is a subtle element in the success of a business enterprise and its head may be wholly unconscious that his rules and regulations are a big factor in drawing trade.

Hospitals are not competitive. They are not compelled to study this phase of their every day routine in order to get or to retain custom. As a rule they are crowded and it is a matter of indifference to them whether patrons are satisfied or not, provided the outcome of the case has been a cure. If the patient leaves relieved or restored, he ought to be satisfied and frequently is.

But it is a serious question whether the institution should regard that as complete fulfillment of obligation.

The modern hospital knows that a comfortable feeling on the part of the patient is a physiological factor toward a favorable end. What part

do the rules and regulations play in this element we call "comfortable feeling"? This is a question which hospital administrators are called upon to consider. They must forget they are not seeking trade in competition with others. Rules of conduct for patients, employees and visitors are not with the hospital what they are with the merchant. He has a selfish motive. The hospital has the unselfish interest of its patients at heart. Hospital discipline is often unnecessarily harsh, petty, pedantic, chaffing employees and irritating both patient and public, when it might just as well be mild or so soft as not to be felt.

It seems to be easy for a physician to become a martinet. Often this type is found at the head of a hospital. Not only is his personality objectionable to employees and patrons but his rules and discipline, being a reflection of his small character, render the institution almost unbearable with their very pettiness and flavor of small tyranny.

This class of professional administrator is often discovered in charge of publicly or tax supported institutions. The military officer, accustomed to the imposition of severe discipline, forgets, when he becomes manager of a hospital, that he is dealing with a different situation. Political doctors, of inconsequential proportions, are elevated to superintendencies of great institutions and there develop a new character. Feeling their authority and being without the balance wheel of experience in large affairs, they soon begin to inflict penalties and devise stiff regulations as the cure-all for real or imaginary defects in their organization, wholly oblivious to the fact that they and not rules or absence of rules are responsible for inharmonious relations and failures.

Good order among employees, loyal support by them of hospital policies and aims, smooth operation, contentment of patients and public will be found where morale has sprung from mutual interest and the spirit to serve. Rules and regulations of themselves never produce morale nor create a spirit, but a few necessary rules develop and grow, naturally as it were, from this morale and spirit to serve. A hospital that has these two elements working for it is little worried about rules and regulations. Where these elements are absent, the superintendent and trustees will surely be found trying to devise substitutes in the form of a book of rules. Whenever an institution is governed from an elaborate rule book, or new regulations are issued daily from headquarters, one may be sure that something fundamental is wrong.

To paraphrase an old saying about government, the best hospital is the least governed hospital.

HOSPITAL LABOR PROBLEMS

RECONSTRUCTION as it is affected by labor seriously troubles hospitals. The public is demanding a higher standard of service in the hospitals because it is paying a higher price. It overlooks the fact that the higher price is to cover the higher cost of the former service. Higher prices are charged and collected for every service and commodity the public needs, but it does not demand any better for the higher price. When it buys hospital service, however, it wants more service in proportion with the higher price.

Labor is a material factor in increasing the cost of hospital service. Labor, as we use the term, includes both the salary and the wage classes.

First: It is necessary to convince the public that hospital operation has gone up like everything else man needs, and better service than formerly was given cannot be furnished on present schedules. This a subject for propaganda.

Second: Hospitals will have to study the methods of commercial and manufacturing businesses in curtailing labor. Introduction of labor-saving devices must follow. Consideration of this matter has not developed in hospitals because until recently they have been able to get help at small wages and long hours. This is not possible now. Hospitals face the eight hour day and must get ready for it.

Third: The shortage of registered nurses and of pupils in training is a serious handicap. It means a reorganization of internal management and the training of the registered nurse to perform a greater and more skillful supervisory and administrative function on the same energy. A class to be known as attendants who neither are pupils nor are likely to be, can be trained to do much of the work that has fallen upon the registered nurse or the advanced pupil.

Fourth: In hospital planning and construction architects and hospital administrators may incorporate many labor-saving devices, that will eliminate steps and waits and, at the same time, make the supervision of employees and service easy and more effective. The relation between emergency service, dispensary service and the methods of large industry incorporated in their factories and offices to save time and the physical strength of employees, to provide supervision at the least possible cost and to eliminate items of expense, both little and big, will bear study by the hospital planner.

Fifth: Dispensary and out-patient service, improved and extended, and earlier detection and diagnosis through the means of public health agencies together will serve to reduce the demands on the hospital.

Altogether the readjustment of hospital and labor involves as many knotty problems as may be found in any industrial or mercantile enterprise, but it will be easier in the latter than in the former. It is the serious duty of every hospital man and woman to give the problem close thought and to contribute his ideas to the benefit of all.

DISCOUNTS AS DONATIONS

IN AN effort to economize, some hospitals make it a practice to ask jobbers and wholesalers with whom they deal to discount their regular prices from time to time, and to regard these discounts as in the nature of donations to the institution. Commendable as is every legitimate effort to economize, this method does not commend itself to us. To institutions that are important enough, manufacturers will occasionally reluctantly grant the discounts, and hospitals here and there may seemingly profit by such practices. By and large, however, these donations will be added to selling costs, and ultimately find their way into the prices charged the hospital field at large.

1921 LIST SHOWS MANY ADDITIONS

THE American College of Surgeons' 1921 list of approved hospitals, which was made public at the Clinical Congress held at Philadelphia on October 24, 1921, shows that the College has made considerable headway with its program of minimum standards since the publication of its 1920 list. (See THE MODERN HOSPITAL, November, 1920, page 420.) These lists, we need hardly remind our readers, apply thus far only to general hospitals of 100 or more beds, in the United States and Canada. The 1920 list, as finally compiled, contains 407 hospitals out of a group of 695; the 1921 list contains 564, or 74 per cent of the 761 general hospitals. This represents a gain of 176 hospitals during the past year. In 1918 only eighty-nine general hospitals of 100 or more beds met the standards, while in 1919 there were 198. In this connection it is interesting to note that 176, or 25 per cent of the 704 general hospitals of fifty to 100 beds visited by representatives of the College during the past two years, have also met the minimum standard. A list of the institutions in this group which met the College's requirements will be published next year.

This progress indicates not only that the minimum standards, as formulated by the College, are practicable, but that there is an increasing desire on the part of our hospitals to qualify for efficient service to their patients.

But what of the 197 hospitals of 100 beds and

more that are not yet included in the list? In few, if any, instances is their absence from the list due to lack of funds. In some cases it is due to the unethical practice of fee splitting among the medical staff. In the main, however, it is due to an inadequate record system and the lack of a regular, periodical review of the professional work of the medical staffs, and this in turn is due fundamentally to the absence of adequate hospital organization.

This problem, however, is not an unsolvable one, and we look to see the 1922 list of the College contain 90 per cent or more of the hospitals of 100 or more beds. A list containing all of the hospitals of this group, though scarcely to be looked for in the very near future, would certainly reflect great credit upon their enterprise and good faith.

STEEPLE JACKS

ACROSS from my office window is a massive building. On the corner of the building is a round, dome-like tower. On the lower edge of that tower at this moment is a boy perilously near to vacant space brushing the side of the tower. He is whistling nonchalantly as he works, now and then craning his neck over the edge to see what is going on in the street below. My heart stands still as I watch him!

Involuntarily I ask myself, "Why is he doing that? Why is he risking his life so unconcernedly? Why hasn't he one of those belts, which at least look efficient, around his waist?" Well—I suppose he is doing that because it is his job. We are all in the same boat—society's—and only if each one of us does his amount of rowing will the boat move forward. And he is doing his rowing so gaily, without a thought of "This is pretty dangerous business, I think I ought to have some safety apparatus."

He ought to have the safety belt, yes, anyone will agree to that, but he hasn't, and yet he goes ahead with his work quite as faithfully as if he had. We haven't all of us ideal working conditions or all the equipment we may desire, but are we going ahead gaily without self-pity, using every bit of our energy and resource, both material and spiritual, in doing our job?

Mr. Galsworthy, in the October issue of *The Yale Review*, says that this is an age of "camouflaged commercialism, wherein to do things well, for the joy of doing them well, is rarer than we think."

Then he goes on to say, "But let us give the devil its due. Let us admit at once that in spite of everything this is still the best age, on the whole, that man has lived in. It is in its own

way very thorough—our modern civilization. It has made advertisement into a fine art, equipped bedrooms with telephones; it diagnoses maladies with extreme punctilio. A doctor examined a young lady the other day, and among his notes were these: 'Not afraid of small rooms, ghosts, or thunderstorms; not made drunk by hearing Wagner; brown hair, artistic hands; had a craving for chocolate in 1918.'"

But there is a kind of "deadly practicality" about this thoroughness, says Mr. Galsworthy. He is arguing for the cult of beauty, which he defines in what seems to me a strikingly fine way, as "a higher and wider conception of the dignity of human life." Hospitals, I believe, more than any other institution today, have within their grasp the opportunity to dignify human life. That is one of the largest parts of their social rowing—will they do it?

PSYCHOPATHIC WARD FOR CHILDREN

THE account of the Cleveland Babies' and Children's Hospital in the September number of the MODERN HOSPITAL (p. 187), is interesting from two angles. First, splendid provision has been made for research and study. Second, there is a psychopathic ward, but very striking is the small space devoted to its description. We hope that it is not to be so insignificant in practice.

A hospital which is to serve the purpose for which this one has been planned will receive children, a large proportion of whom should be observed and studied for mental deficiencies or obliquities. Children, for instance, who have been born in poverty are not necessarily psychopathic but, in the modern conception of things, poverty is not conducive either to mental or physical health. The conditions of poverty which will bring many children into this hospital for physical treatment are likely to be responsible for mental troubles, not yet discernible except by the trained and experienced expert in mental diseases.

Children born into the world crippled and deformed may be mentally at par, but a study of them and of their heredity and environment is just as essential to their future as are the study and correction of their physical defects.

Any institution, public or private, which specializes in children's diseases, is performing only part of its mission when it applies itself to the physical being alone and neglects the mental, because, perhaps, there has developed nothing the naked eye can see.

We take it that the elaborate provision made in this institution for research has included a liberal and very generous use of the psychopathic ward.

HOSPITAL STANDARDIZATION MAKES HEADWAY*

SINCE the inception of the movement for the standardization of hospitals by the American College of Surgeons in 1915, and after the minimum standard was evolved from the combined experience of surgeons, internists, and hospital executives, it has met with increasing recognition, until today 74 per cent of the hundred bed hospitals in the United States and Canada have adopted it.

Surely, the time for debate has passed. It is beside the mark to argue the wisdom of a movement which has enlisted the cooperation of three-fourths of hospital America. Any advance in medicine must begin—and end—with the welfare of the patient. He must be at once the actuating impulse and the final beneficiary. Just so surely as the patient is benefited, so also will be the doctor and the hospital. And, precisely, because the minimum standard was evolved to bring every group in the hospital together to work for the patient, it created an organization which resulted in better work for the individual surgeon, internist, hospital superintendent, and nurse.

The minimum standard embodies the basic principles of scientific research. Research begins with securing facts, compiling facts, analyzing facts. This done, research draws tentative conclusions gained from analysis of the facts. These conclusions, if supported by sufficient evidence and corroborated by practice, become known as scientific truths.

This standard consists of a working arrangement by which these same principles of research are applied daily in the hospital for the benefit of the patient. Accurate, adequate case records, modern laboratory equipment manned by skilled technicians—what are these but provisions to marshal the facts before the physician for examination? The monthly clinical staff meeting—what is this but an opportunity to test out the data which the records and laboratories have furnished? Insistence on competent and ethical practitioners—what is this but insurance that the interpreters of the facts regarding each patient are skilled medical men, on whose judgment the public has every right to rely? The working formula for this program is the minimum standard.

The minimum standard is, in essence, an arrangement by which the hospital can insure its patients the best care known to the science of medicine. We have shown how it provides an application of the principles of scientific research to the care of the patient—the same principles which the individual doctor or surgeon uses for arriving at a diagnosis. And because medical men the country over were quick to see not only the practical but the scientific basis underlying the minimum standard, they have given it, in increasing numbers, their unqualified support.

It is easy to devise a system of rules which—on paper—is perfect. It is quite another matter to evolve a standard of such simplicity that it stands the test of actual conditions in hospital work. Whether the minimum standard is eminently practicable in the every day administration of hospitals is best answered by the following report:

The Acceptance of the Program

In 1918, of the general hospitals of one hundred or more beds in the United States and Canada, eighty-nine met the standard. In 1919, 198 fulfilled the requirements; in 1920

407 or 57 per cent, met the standard; and this year 564 or 74 per cent of the 761 general hospitals are on the "approved" list.

Further, what has been the experience of other organizations interested in hospital betterment? Manifestly, their reaction toward the program furnishes another reliable index as to its applicability. A decided impetus has been given to hospital standardization by the acceptance and endorsement of the minimum standard by such influential and powerful organizations as the American Hospital Association, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

The Method and Scope of the Work

The hospital surveys of the College are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. Their purpose is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existent shortcomings. Upon these detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

An important adjunct to the work of the hospital surveyors has been the emphasis placed on hospital standardization at the state and provincial sectional meetings of the College. At these meetings conferences are held which are devoted to a discussion of pertinent hospital problems by those intimately connected with hospitals. In addition, the community interest is stimulated at public meetings where the benefits of hospital standardization are portrayed.

In 1920, the general hospitals of one hundred or more beds in the United States and Canada were visited. A complete report of last year's survey is contained in bulletin No. 1, Vol. 5, issued by the College in January, 1921. This year particular attention has been directed toward those hospitals which in 1920 either were not included in the list, or which were listed with an asterisk. Hospitals which were fully approved in 1920 were not as a routine visited this year, although in all probability visits to these institutions will be resumed in the future.

In addition, 704 general hospitals of fifty to one hundred beds were visited during the past two years, 306 in 1920 and 398 in 1921. As there are approximately 854 of these smaller hospitals in the United States and Canada, 150 remain to be visited. Of these 704 visited during 1920 and 1921, 176, or 25 per cent, of the total number met the standard. The individual listing of this group of institutions will appear next year.

The Program for the Future

Consequently, the survey of 1922 will be extended to include all general hospitals of fifty beds and over in the United States and Canada. Of these institutions already visited, many showed a working knowledge of the minimum standard and evinced an active desire to cooperate. The percentage of these meeting the standard at their first visit compares favorably with the percentage of hundred bed hospitals which were approved on their first inspection. If proof were needed of the universal appli-

*From a report of the American College of Surgeons' Survey of Hospitals for 1921, read at the Clinical Congress in Philadelphia on Oct. 24, 1921.

cation of the minimum standard, the acceptance by the smaller hospitals would furnish it. Stressing only broad fundamentals, the minimum standard moulds itself to meet specific needs, nowhere impeding initiative, or fettering judgment. Rightly conceived and carried out, it makes the hospital the proved guardian of the community health, rendering scientific service to all.

Capacity of 100 Beds and Over

The following list contains the names of those general hospitals of one hundred or more beds, in the United

States and Canada, which meet the minimum standard. In this list a certain number of the institutions are designated with an asterisk. This group includes those hospitals which, when visited, had adopted the fundamental principles of the minimum standard, but which at that time had not had sufficient opportunity to develop all of them to a degree meriting the fullest approval. The hospitals listed without an asterisk, having instituted these measures at an earlier date, had received the benefits of a longer experience in the workings of the program and consequently a broader conception of its application.

UNITED STATES¹

ALABAMA

Employees Hospital, T. C. I. & R. R. Co., Birmingham
*Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
South Highlands Infirmary, Birmingham

ARKANSAS

*Logan H. Roots Memorial Hospital, Little Rock
St. Louis Southwestern Hospital, Texarkana
St. Vincent's Hospital, Little Rock

CALIFORNIA

Alameda County Hospital, San Leandro
Children's Hospital, San Francisco
*Franklin Hospital, San Francisco
*French Hospital, San Francisco
*Hospital of the Good Samaritan, Los Angeles
Lane Hospital, San Francisco
Los Angeles County Hospital, Los Angeles
Mary's Help Hospital, San Francisco
Mt. Zion Hospital, San Francisco
*O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
*Providence Hospital, Oakland
St. Francis' Hospital, San Francisco
St. Joseph's Hospital, San Francisco
St. Joseph's Sanitarium, San Diego
*St. Luke's Hospital, San Francisco
St. Mary's Hospital, San Francisco
St. Vincent's Hospital, Los Angeles
San Diego County Hospital, San Diego
San Francisco County Hospital, San Francisco
*San Joaquin County Hospital, French Camp
Santa Barbara Cottage Hospital, Santa Barbara
Santa Clara County Hospital, San Jose
Santa Fe Coast Lines Hospital, Los Angeles
Southern Pacific Hospital, San Francisco
*Stanford Hospital, San Francisco
University of California Hospital, San Francisco
White Memorial Hospital, Los Angeles

COLORADO

*Denver City and County Hospital, Denver
Glockner Sanatorium and Hospital, Colorado Springs
*Mercy Hospital, Denver
Minnequa Hospital, Pueblo
St. Anthony's Hospital, Denver
*St. Francis' Hospital, Colorado Springs
*St. Mary's Hospital, Pueblo

CONNECTICUT

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
Lawrence and Memorial Associated Hospitals, New London
New Haven Hospital, New Haven
St. Francis' Hospital, Hartford
St. Mary's Hospital, Waterbury
St. Vincent's Hospital, Bridgeport
*Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

DELAWARE

Delaware Hospital, Wilmington

DISTRICT OF COLUMBIA

Central Dispensary and Emergency Hospital, Washington
Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedman's Hospital, Washington
Garfield Memorial Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Providence Hospital, Washington
*Washington Sanitarium, Washington

GEORGIA

Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
University Hospital, Augusta

¹This is complete only to October 4, when the American College of Surgeons' report went to press.

IDAHO

St. Alphonsus Hospital, Boise

ILLINOIS

Alexian Brothers' Hospital, Chicago
*American Hospital, Chicago
Augustana Hospital, Chicago
Chicago Lying-In Hospital, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Cook County Hospital, Chicago
Evanston Hospital, Evanston
*Frances E. Willard Hospital, Chicago
Grant Hospital, Chicago
Hahnemann Hospital, Chicago
Illinois Central Hospital, Chicago
*Illinois Charitable Eye and Ear Infirmary, Chicago
*John C. Proctor Hospital, Peoria
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
St. Anne's Hospital, Chicago
St. Bernard's Hospital, Chicago
*St. Elizabeth's Hospital, Chicago
*St. Elizabeth's Hospital, Danville
St. Francis' Hospital, Blue Island
*St. Francis' Hospital, Evanston
*St. Francis' Hospital, Peoria
St. Joseph's Hospital, Chicago
St. Luke's Hospital, Chicago
*St. Mary's Hospital, Cairo
*St. Mary's Hospital, East St. Louis
St. Mary's Hospital, La Salle
St. Mary of Nazareth Hospital, Chicago
*St. Vincent's Hospital, Belleville
South Shore Hospital, Chicago
Swedish Covenant Hospital, Chicago
Wesley Memorial Hospital, Chicago

INDIANA

Indianapolis City Hospital, Indianapolis
Methodist Episcopal Hospital, Indianapolis
Robert W. Long Hospital, Indianapolis
St. Anthony's Hospital, Terre Haute
St. Elizabeth's Hospital, LaFayette
St. Joseph's Hospital, Fort Wayne
St. Margaret's Hospital, Hammond
St. Mary's Hospital, Evansville
St. Mary's Mercy Hospital, Gary
St. Vincent's Hospital, Indianapolis

IOWA

Finley Hospital, Dubuque
Iowa Lutheran Hospital, Des Moines
Jennie Edmundson Hospital, Council Bluffs
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
*Mercy Hospital, Des Moines
St. Francis' Hospital, Waterloo
St. Joseph's Mercy Hospital, Dubuque
St. Joseph's Mercy Hospital, Sioux City
St. Vincent's Hospital, Sioux City
University Hospital, Iowa City

KANSAS

*Bethany Methodist Hospital, Kansas City
St. Francis' Hospital, Wichita
St. Margaret's Hospital, Kansas City

KENTUCKY

Good Samaritan Hospital, Lexington
Louisville City Hospital, Louisville
Norton Memorial Infirmary, Louisville
St. Anthony's Hospital, Louisville
*St. Elizabeth's Hospital, Covington
Sts. Elizabeth and Mary Hospital, Louisville
St. Joseph's Hospital, Lexington
St. Joseph's Infirmary, Louisville

LOUISIANA

Charity Hospital, New Orleans
*Hotel Dieu, New Orleans
St. Francis Hospital, Monroe
T. E. Schumpert Memorial Hospital, Shreveport
Touro Infirmary, New Orleans

MAINE

Eastern Maine General Hospital, Bangor
*St. Mary's General Hospital, Lewiston

MARYLAND

Bay View City Hospital, Baltimore

Church Home and Infirmary, Baltimore
*Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
Morrow Hospital, Baltimore
St. Agnes' Hospital, Baltimore
St. Joseph's Hospital, Baltimore
Union Memorial Hospital, Baltimore
University Hospital, Baltimore

MASSACHUSETTS

Boston City Hospital, Boston
Brockton Hospital, Brockton
Burbank Hospital, Fitchburg
Cambridge City Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
*Cooley-Dickinson Hospital, Northampton
Holyoke City Hospital, Holyoke
Lawrence General Hospital, Lawrence
Long Island Hospital, Boston
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
Massachusetts General Hospital, Boston
Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
Peter Brent Brigham Hospital, Boston
Providence Hospital, Holyoke
St. Elizabeth's Hospital, Boston
St. John's Hospital, Lowell
*St. Luke's Hospital, New Bedford
St. Vincent's Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
Worcester City Hospital, Worcester

MICHIGAN

Battle Creek Sanitarium, Battle Creek
Blodgett Memorial Hospital, Grand Rapids
Butterworth Hospital, Grand Rapids
Children's Free Hospital, Detroit
Detroit Receiving Hospital, Detroit
Grace Hospital, Detroit
Harper Hospital, Detroit
Hackley Hospital, Muskegon
Henry Ford Hospital, Detroit
Highland Park General Hospital, Highland Park
House of Providence, Detroit
St. Joseph's Hospital, Ann Arbor
St. Mary's Hospital, Grand Rapids
St. Mary's Hospital, Detroit
University Hospital, Ann Arbor
University of Michigan Homeopathic Hospital, Ann Arbor
Woman's Hospital and Infant's Home, Detroit

MINNESOTA

Bethesda Hospital, St. Paul
City and County Hospital, St. Paul
Colonial Hospital, Rochester
Deaconess Hospital, Minneapolis
*Eitel Hospital, Minneapolis
*Fairview Hospital, Minneapolis
Minneapolis General Hospital, Minneapolis
Mounds Park Sanitarium, St. Paul
St. Joseph's Hospital, St. Paul
*St. Luke's Hospital, St. Paul
St. Mary's Hospital, Duluth
St. Mary's Hospital, Minneapolis
St. Mary's Hospital, Rochester
*St. Paul Hospital, St. Paul
*Swedish Hospital, Minneapolis
University of Minnesota Hospital, Minneapolis
Worrell Hospital, Rochester

MISSISSIPPI

Matty Hersee Hospital, Meridian

MISSOURI

Alexian Brothers' Hospital, St. Louis
Barnes Hospital, St. Louis
Children's Hospital, Kansas City

*Christian Church Hospital, Kansas City
 *Evangelical Deaconess Home and Hospital, St. Louis
 Jewish Hospital, St. Louis
 Kansas City General Hospital, Kansas City
 Lutheran Hospital, St. Louis
 *Mullanphy Hospital, St. Louis
 Research Hospital, Kansas City
 St. Anthony's Hospital, St. Louis
 St. John's Hospital, St. Louis
 St. Joseph's Hospital, Kansas City
 St. Louis Children's Hospital, St. Louis
 St. Louis City Hospital, St. Louis
 St. Luke's Hospital, St. Louis
 St. Mary's Hospital, Kansas City
 St. Mary's Infirmary, St. Louis

MONTANA

Columbus Hospital, Great Falls
 Montana Deaconess Hospital, Great Falls
 Murray Hospital, Butte
 St. James' Hospital, Butte
 St. Patrick's Hospital, Missoula

NEBRASKA

*Nebraska Methodist Hospital, Omaha
 *Nebraska Orthopedic Hospital and Home, Lincoln
 St. Elizabeth's Hospital, Lincoln
 St. Francis' Hospital, Grand Island
 St. Joseph's Hospital, Omaha
 *St. Mary's Hospital, Columbus
 University of Nebraska Hospital, Omaha

NEW HAMPSHIRE

St. Joseph's Hospital, Nashua

NEW JERSEY

*Alexian Brothers Hospital, Elizabeth
 Atlantic City Hospital, Atlantic City
 Bayonne Hospital and Dispensary, Bayonne
 Christ Hospital, Jersey City
 Cooper Hospital, Camden
 Elizabeth General Hospital, Elizabeth
 Hackensack Hospital, Hackensack
 Jersey City Hospital, Jersey City
 Mercer Hospital, Trenton
 Monmouth Memorial Hospital, Long Branch
 Morristown Memorial Hospital, Morristown
 Mountainside Hospital, Montclair
 Muhlenberg Hospital, Plainfield
 Newark Beth Israel Hospital, Newark
 Newark City Hospital, Newark
 Newmark Memorial Hospital, Newmark
 Orange Memorial Hospital, Orange
 Passaic General Hospital, Passaic
 Paterson General Hospital, Paterson
 St. Elizabeth's Hospital, Elizabeth
 St. Francis' Hospital, Trenton
 *St. Joseph's Hospital, Paterson
 *St. Mary's Hospital, Hoboken
 *St. Michael's Hospital, Newark

NEW YORK

Albany Hospital, Albany
 Bellevue Hospital, New York
 Beth Israel Hospital, New York
 Beth Moses Hospital, Brooklyn
 *Binghamton City Hospital, Binghamton
 Broad Street Hospital, New York
 Brooklyn Hospital, Brooklyn
 Brownsville and East New York Hospital, Brooklyn
 Buffalo City Hospital, Buffalo
 Buffalo General Hospital, Buffalo
 *Buffalo Homeopathic Hospital, Buffalo
 *Buffalo Hospital of Sisters of Charity, Buffalo
 *Bushwick Hospital, Brooklyn
 Carson C. Peck Memorial Hospital, Brooklyn
 *Children's Hospital, Buffalo
 Clifton Springs Sanitarium, Clifton Springs
 Community Hospital, New York
 Coney Island Hospital, Brooklyn
 *Crouse-Irving Hospital, Syracuse
 Cumberland Street Hospital, Brooklyn
 Ellis Hospital, Schenectady
 *Flower Hospital, New York
 Flushing Hospital and Dispensary, Flushing
 Fordham Hospital, New York
 French Benevolent Hospital, New York
 *Good Shepherd Hospital, Syracuse
 Gouverneur Hospital, New York
 Greenpoint Hospital, Brooklyn
 Hahnemann Hospital, New York
 Hahnemann Hospital, Rochester
 Harlem Hospital, New York
 Holy Family Hospital, Brooklyn
 Homeopathic Hospital, Albany
 Jewish Hospital, Brooklyn
 Kings County Hospital, Brooklyn
 Lebanon Hospital, New York
 *Lenox Hill Hospital, New York
 Lincoln Hospital, New York
 Long Island College Hospital, Brooklyn
 *Manhattan Eye and Ear Hospital, New York
 Memorial Hospital, New York
 Methodist Episcopal Hospital, Brooklyn
 Metropolitan Hospital, New York
 Misericordia Hospital, New York
 Mount St. Mary's Hospital, Niagara Falls
 Mount Sinai Hospital, New York
 *Mount Vernon Hospital, Mount Vernon
 New York City Hospital, Blackwell's Island, New York

*New York Eye and Ear Infirmary, New York
 *New York Foundling Home, New York
 New York Hospital, New York
 New York Infirmary for Women and Children, New York
 New York Nursery and Children's Hospital, New York
 New York Orthopedic Hospital, New York
 New York Post-Graduate Hospital, New York
 New York Hospital for Ruptured and Crippled, New York
 New York Skin and Cancer Hospital, New York
 *New York State Hospital for Crippled Children, West Haverstraw
 *Niagara Falls Memorial Hospital, Niagara Falls
 Norwegian Lutheran Deaconess Hospital, Brooklyn
 *Oneida County Hospital, Rome
 Presbyterian Hospital, New York
 Rochester General Hospital, Rochester
 Rochester Homeopathic Hospital, Rochester
 Roosevelt Hospital, New York
 St. Catherine's Hospital, Brooklyn
 St. Francis Hospital, New York
 St. John's Brooklyn Hospital, Brooklyn
 St. John's Hospital, Long Island
 St. John's Riverside Hospital, Yonkers
 *St. Joseph's Syracuse Hospital, Syracuse
 St. Luke's Hospital, New York
 St. Mark's Hospital, New York
 St. Mary's Free Hospital for Children, New York
 St. Mary's Hospital, Brooklyn
 *St. Mary's Hospital, Rochester
 *St. Peter's Hospital, Albany
 *St. Peter's Hospital, Brooklyn
 St. Vincent's Hospital, New York
 Samaritan Hospital, Troy
 Sloane Hospital for Women, New York
 Staten Island Hospital, Tompkinsville
 Syracuse Memorial Hospital, Syracuse
 Troy Hospital, Troy
 Woman's Hospital, New York
 Wyckoff Heights Hospital, Brooklyn
 *Yonkers Homeopathic Hospital, Yonkers

NORTH CAROLINA

*Watts Hospital, West Durham
 NORTH DAKOTA
 Bismarck Evangelical Deaconess Hospital, Bismarck
 *Grand Forks Deaconess Hospital, Grand Forks
 St. Alexius' Hospital, Bismarck
 St. John's Hospital, Fargo
 St. Luke's Hospital, Fargo

OHIO

*Aultman Hospital, Canton
 Bethesda Hospital, Cincinnati
 Christ Hospital, Cincinnati
 Cincinnati General Hospital, Cincinnati
 City Hospital of Akron, Akron
 Cleveland City Hospital, Cleveland
 Good Samaritan Hospital, Cincinnati
 Good Samaritan Hospital, Zanesville
 Grant Hospital, Columbus
 Hawkes Hospital of Mount Carmel, Columbus
 Jewish Hospital, Cincinnati
 Lakeside Hospital, Cleveland
 Miami Valley Hospital, Dayton
 *Mercy Hospital, Hamilton
 Mount Sinai Hospital, Cleveland
 *Peoples Hospital, Akron
 *Protestant Hospital Association, Columbus
 St. Alexius' Hospital, Cleveland
 St. Elizabeth's Hospital, Youngstown
 St. Francis' Hospital, Columbus
 St. John's Hospital, Cleveland
 *St. Luke's Hospital, Cleveland
 St. Mary's Hospital, Cincinnati
 St. Rita's Hospital, Lima
 St. Vincent's Hospital, Cleveland
 St. Vincent's Hospital, Toledo
 Springfield City Hospital, Springfield
 Toledo Hospital, Toledo
 *Youngstown Hospital, Youngstown

OKLAHOMA

St. Anthony's Hospital, Oklahoma
 State University Hospital, Oklahoma

OREGON

Emanuel Hospital, Portland
 St. Vincent's Hospital, Portland

PENNSYLVANIA

Allegheny General Hospital, Pittsburgh
 Allentown Hospital, Allentown
 Altoona Hospital, Altoona
 Braddock General Hospital, Braddock
 Chester County Hospital, West Chester
 Chester Hospital, Chester
 Children's Homeopathic Hospital, Philadelphia
 Clearfield Hospital, Clearfield
 Columbia Hospital, Pittsburgh
 Conemaugh Valley Memorial Hospital, Johnstown
 *Elizabeth Steel Magee Hospital, Pittsburgh
 Easton Hospital, Easton
 Frankford Hospital, Philadelphia

George F. Geisinger Hospital, Danville
 Germantown Dispensary and Hospital, Philadelphia
 Hahnemann Medical College Hospital, Philadelphia
 *Hamot Hospital, Erie
 Harrisburg Hospital, Harrisburg
 Homeopathic Medical and Surgical Hospital, Pittsburgh
 Hospital of the Protestant Episcopal Church, Philadelphia
 Hospital of the University of Pennsylvania, Philadelphia
 Hospital of the Women's Medical College, Philadelphia
 Jefferson Medical College Hospital, Philadelphia
 Jewish Hospital, Philadelphia
 Lancaster General Hospital, Lancaster
 Lankenau Hospital, Philadelphia
 *Medical, Surgical, and Maternity Hospital of the Women's Homeopathic Association, Philadelphia
 Medico-Chirurgical Hospital, Philadelphia
 *Memorial Hospital, Philadelphia
 Mercy Hospital, Johnstown
 Mercy Hospital, Pittsburgh
 Mercy Hospital, Wilkes-Barre
 Methodist Episcopal Hospital, Philadelphia
 Misericordia Hospital, Philadelphia
 Moses Taylor Hospital, Scranton
 Passavant Hospital, Pittsburgh
 Pennsylvania Hospital, Philadelphia
 Philadelphia General Hospital, Philadelphia
 Philadelphia Polyclinic Hospital, Philadelphia
 Pittsburgh Hospital, Pittsburgh
 Pottsville Hospital, Pottsville
 Presbyterian Hospital, Philadelphia
 Presbyterian Hospital Pittsburgh
 Reading Hospital, Reading
 *Robert Packer Hospital, Sayre
 Sacred Heart Hospital, Allentown
 St. Agnes' Hospital, Philadelphia
 St. Francis' Hospital, Pittsburgh
 *St. John's General Hospital, Pittsburgh
 *St. Joseph's Hospital, Lancaster
 St. Joseph's Hospital, Philadelphia
 St. Joseph's Hospital, Pittsburgh
 St. Luke's Hospital, South Bethlehem
 St. Margaret's Hospital, Pittsburgh
 St. Mary's Hospital, Philadelphia
 St. Vincent's Hospital, Erie
 Samaritan Hospital, Philadelphia
 South Side Hospital, Philadelphia
 *State Hospital for Injured Persons, Ashland
 State Hospital for the Middle Coal Fields, Hazleton
 *State Hospital of the Northern Anthracite Coal Regions, Scranton
 *Western Pennsylvania Hospital, Pittsburgh
 Wilkes-Barre City Hospital, Wilkes-Barre
 Wills Hospital, Philadelphia
 Woman's Hospital, Philadelphia
 York Hospital and Dispensary, York

RHODE ISLAND

Rhode Island Hospital, Providence
 St. Joseph's Hospital, Providence

SOUTH CAROLINA

Chick Springs Sanitarium, Chick Springs
 Florence Infirmary, Florence
 Roper Hospital, Charleston

SOUTH DAKOTA

McKenna Hospital, Sioux Falls
 *St. Luke's Hospital, Aberdeen

TENNESSEE

Baptist Memorial Hospital, Memphis
 Erlanger Hospital, Chattanooga
 Memphis General Hospital, Memphis
 St. Joseph's Hospital, Memphis
 St. Thomas' Hospital, Nashville

TEXAS

Baptist Sanitarium and Hospital, Houston
 Baylor Hospital, Dallas
 John Sealy Hospital, Galveston
 *Parkland Hospital, Dallas
 Providence Hospital, Waco
 Robert B. Green Memorial Hospital, San Antonio
 St. Joseph's Infirmary, Fort Worth
 St. Joseph's Infirmary, Houston
 St. Mary's Infirmary, Galveston
 St. Paul's Sanitarium, Dallas
 Santa Rosa Infirmary, San Antonio
 Temple Sanitarium, Temple

UTAH

*Doctor W. H. Groves Latter Day Saints Hospital, Salt Lake City
 Holy Cross Hospital, Salt Lake City
 St. Mark's Hospital, Salt Lake City

VERMONT

Mary Fletcher Hospital, Burlington

VIRGINIA

Hospital Division of the Medical College of Virginia, Richmond
 Norfolk Protestant Hospital, Norfolk
 St. Vincent's Hospital, Norfolk

University of Virginia Hospital, Charlottesville
Virginia Hospital, Richmond

WASHINGTON

Children's Orthopedic Hospital, Seattle
Columbus Sanitarium, Seattle
*Northern Pacific Hospital, Tacoma
Providence Hospital, Seattle
Sacred Heart Hospital, Spokane
St. Elizabeth's Hospital, North Yakima
St. Joseph's Hospital, Tacoma
St. Luke's Hospital, Spokane
Seattle City Hospital, Seattle
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

WEST VIRGINIA

*Charleston General Hospital, Charleston
Kessler-Hatfield Hospital, Huntington
Ohio Valley General Hospital, Wheeling
St. Mary's Hospital, Clarksburg
Sheltering Arms Hospital, Hansford
*Wheeling Hospital, Wheeling

WISCONSIN

LaCrosse Lutheran Hospital, LaCrosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Milwaukee County Hospital, Milwaukee
*Milwaukee Hospital, Milwaukee

Mount Sinai Hospital, Milwaukee
Sacred Heart Hospital, Eau Claire
St. Agnes' Hospital, Fond du Lac
St. Francis' Hospital, LaCrosse
St. Joseph's Hospital, Marshfield
St. Joseph's Hospital, Milwaukee
St. Mary's Hospital, Green Bay
St. Mary's Hospital, Superior
*Trinity Hospital, Milwaukee

CANADA

ALBERTA

General Hospital, Calgary.
*General Hospital, Edmonton.
General Hospital, Medicine Hat.
Holy Cross Hospital, Calgary.
*Royal Alexandra Hospital, Edmonton.

BRITISH COLUMBIA

Provincial Royal Jubilee Hospital, Victoria
Royal Columbia Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

MANITOBA

Children's Hospital, Winnipeg
General Hospital, Winnipeg
Misericordia Hospital, Winnipeg

St. Boniface Hospital, St. Boniface

NEW BRUNSWICK

General Hospital, St. John

NOVA SCOTIA

St. Joseph's Hospital, Glace Bay
Victoria General Hospital, Halifax

ONTARIO

*General Hospital, Hamilton
General Hospital, Kingston
Grace Hospital, Toronto
Hospital for Sick Children, Toronto
Hotel Dieu, Kingston
St. Michael's Hospital, Toronto
*Toronto General Hospital, Toronto
Victoria General Hospital, London

QUEBEC

Children's Memorial Hospital, Montreal
Hotel Dieu, Montreal
Jeffrey Hale Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Royal Victoria Hospital, Montreal
*Western Hospital, Montreal

SASKATCHEWAN

City Hospital, Saskatoon
Grey Nun's Hospital, Regina
Regina General Hospital, Regina
St. Paul's Hospital, Saskatoon

TUBERCULOSIS CONFERENCE MEETS

Approximately five hundred delegates were registered for the Mississippi Valley Tuberculosis Conference, one of the largest and most successful in its nine years' history.

Reports from each of the states in the Mississippi Valley indicated a further decline in the tuberculosis death rate for 1921. These reports covered a ten year period and some indicated that when official statistics for 1921 are available, they will be able to show a reduction of 50 per cent in the tuberculosis death rate as compared with the figures of ten years ago. This reduction in tuberculosis mortality rates was attributed in a large measure to the educational work carried on during the past ten years in these states. Dr. Walter McNab Miller, St. Louis, the president of the Conference, ventured the prediction that another decade will see the absolute control of tuberculosis in this country.

With such well known authorities as Dr. Allen K. Krause, Baltimore, Md., editor of the *American Review of Tuberculosis*; Dr. James Alexander Miller, New York, president of the National Tuberculosis Association; and Dr. Haven Emerson, formerly of the United States Veterans' Bureau, on the program, the proceedings of the conference, which will be printed later, will be of great value to those engaged in tuberculosis work throughout the country.

Of outstanding importance was the address of Dr. Krause on the subject: "Solving Tuberculosis—a Many Sided Problem." He urged a larger dissemination of knowledge concerning the disease, commended the work of training children in proper health habits and urged more research work. "If society is to make notable progress against tuberculosis, it must encourage research work," he said.

Dr. Emerson's scathing denunciation of political methods, which he said were being used in the administration of the United States Veterans' Bureau at Washington, attracted nation-wide attention and brought from the director of the Bureau at Washington an immediate reply, in which he announced that Dr. Emerson would be summarily dismissed from the service. His resignation was to have taken effect September 15, two days after this speech.

Speaking on the problem of the tuberculous ex-soldiers, Dr. Emerson endorsed what Dr. David Lyman recently

said about the soldiers themselves being one of the greatest handicaps in the movement to provide for their relief, and added this further comment on the attitude of the veterans: "We are facing a series of relationships new in medical experience in this country. We find patients eager to be found sick, grateful for declaration that they are worse, hopeful of continued disability, resenting attempts to persuade them that the will to win is tantamount to recovery, clinging to any straw that will permit them to stay on the hospital roster, indifferent to truth if the monthly check can be increased, reckless in their expenditures for luxuries and gambling and the vices of drugs and liquor, of what is meant to serve them in the period after hospital care when they will be introduced again to the responsibilities of self-support.

"Against this anti-social, unpatriotic, selfish attitude, the whole weight of the medical, nursing and other staffs of hospitals is now directed," said Dr. Emerson, "and it is a struggle between character and intelligence on one side and a still demoralized clientele on the other, which has been so fed and pampered by sentiment that sense has a hard row to hoe."

Dr. Emerson also said that an authoritative report upon standards and rules for discipline and treatment of tuberculosis patients, beneficiaries of the United States Veterans' Bureau, has been prepared by a committee of the National Tuberculosis Association and the American Sanatorium Association, and this, when published and distributed, is certain, he feels, to produce a profound effect upon the men and the character of government institutional care.

The conference adopted a resolution which seeks to clarify the situation relative to general hospitals opening wards for the treatment of tuberculosis. The resolution declares there has been a tendency on the part of the public and public officials in some quarters to interpret resolutions recently adopted by the National Tuberculosis Association, the American Medical Association, and the American Hospital Association, as indicating that such wards may take the place of sanatoriums. Attention is directed to the fact that the real purpose of this policy is that wards in general hospitals are intended in no way to supercede sanatoriums, but to supplement them as clearing houses for diagnosis, for advanced cases, for teaching and emergency purposes.

HOW HOSPITAL RECORDS CAN CONTRIBUTE TO HEALTH PROTECTION*

BY HAVEN EMERSON, M.D., NEW YORK CITY

AS THE individual physician is licensed so will the collective medical services of the hospital be licensed and in an increasing measure operate under certain standards of location, equipment, and administration and be required to give an accounting of its contact with the sick of the community.

Quoting from the report of the Bureau of Hospitals of the State Department of Health of Ohio, January 1, 1921, the following are significant opinions widely held but not yet universally recognized or effectively acted upon throughout the country:

"To appreciate thoroughly the public character of the hospital it must be regarded as a public utility."

"The hospital is essentially a private corporation filling a positive public need. Its sole function is the protection of the public health, and the difference between efficient and inefficient hospital performance is the difference between life and death of human beings."

"Again the functions of these institutions recognized as public utilities are executed by lay individuals while hospital functions are largely administered by a professional personnel, principally physicians and nurses who are licensed or registered as individuals by a public office upon their demonstration to meet prescribed qualifications."

"Moreover, hospital functions embrace activities beyond the scope of medical and nursing practice, and independent of all medical service and the most accomplished nursing can give."

"It is those facilities and activities constituting the difference between home and hospital care that differentiate between medical practice and hospital performance."

It will be recalled also that various summaries of hospital services have shown that from 85 to 95 per cent of all hospital beds are in institutions supported by taxation or by voluntary subscription of the public, and are operated, without financial profit, for the benefit of the public.

It may as well be admitted that the sick with certain group exceptions receive more prompt and accurate diagnosis of their conditions and are treated with better success in hospitals than in homes. Furthermore, expressing the opinion of the Council of Health of the American Medical Association we may agree that the future of curative and preventive medical practice depends upon the provision of such hospital, laboratory, and dispensary facilities supported by the public as will permit the application of modern science in a way impracticable

Hospitals in the future will be licensed as are individual physicians at present, and they will therefore be required to give an account of their contact with the sick.

Aside from the fact that they will be required to give such an account they should do so because in their hands lies the future of preventive medicine. The science of preventive medicine can only advance through the accumulation of facts. These facts mean records. The records will be of three kinds, financial or administrative, social, and medical. On the medical record will diagnosis be based for diagnosis today must be more than a guess.

Records then are demanded in the interest of the hospital's and the physician's conscience, in the interest of the patient's and the community's health, and last and perhaps most far-reaching in the interest of the advancement of science.

through the agency of individual of competitive medical practice.

Granting then for the sake of argument that hospitals are at present and will be in the future to an even greater extent public utilities serving public needs without thought or object of gain other than in merit and credit in public esteem, are they serving all the functions now possible and expected of them in the preventive aspect of medical practice?

To stop a moment before answering directly, let us recall what is the information contained in hospital records. One section would

be financial and what may be called administrative, another social, and the third medical.

Doubtless there are to be found values in health protection in the first two but if so the study of this must come from other sources.

With the medical information I am prepared to deal.

Clinical Record Consists of Facts

Of what does the clinical record of a hospital and dispensary patient consist? There must be social, scientific and administrative facts. There are the patient, the physician, and the hospital to be protected against inadequate service, against loss of data precious to the patient and to society, and against claims that there has been malpractice or neglect. Facts upon which improvements in hospital procedure and management can be based, by which policies and the principles of administration can be tested, require an analysis of the experiences with disease, which the bedside and laboratory services offer. Health, human salvage, relief from pain, from disability, from fever and from anxiety, and postponement of death—these are the hospital's output. How success is attained or failure results, because of or in spite of our knowledge or our ignorance; what is myth and mystery, what is superstition and sentiment, to answer such queries, we turn to the record. The record, not our imagination or our memory of past events, but a painstaking entry on imperishable human documents of what is at the same time the glory and cause of humility of medicine, the truth as we see it, when we see it, the fact as our faltering and unskilled senses take note of it, on the spot, in the presence of suffering humanity, at the autopsy table, while the reaction in test tube or the tissue fragment under the microscope are knocking at our consciousness.

The hospital is the great court before which our social order, our education, our personal habits are exposed in all the tragedy of our failures. How dare we continue our stewardship, we the responsible directors of the human salvage plants, we the servants of the sick offering them

*Read at the Twenty-Third Annual Convention of the American Hospital Association held at West Baden, Ind., Sept. 12-16, 1921.

what we have acquired in the way of science, art, and spirit if we do not as modern apostles write down the record of the lives we are temporarily entrusted with.

Must Have Clinical History for Diagnosis

There is no physician so experienced, or so endowed with intuition that he can make a diagnosis of a *patient*, without a clinical history. A diagnosis of a *disease*, a fracture, malaria, syphilis, diabetes, may be made in the absence of history. But what of the *person* who is sick? Can we afford to know less than all that can be discovered of inheritance, of home, family, background, incidental and ancient difficulties of body and spirit, what has been suffered, what met and overcome? Even the speechless babe has a history, even the patient of foreign tongue needs to tell us what we ought to want to know. A history taken is stolen if not recorded.

The day of clinical impressions is past. We no longer walk in awe at the elbow of the great clinician who makes a diagnosis at arm's length. Diagnosis demands a complete and detailed physical examination of the patient and often a mental study too. Not a study of the lungs only when we expect pneumonia, or of the joints when we talk of rheumatism, but a study of all the body to find out all that is wrong and all that is right and thus save us the humiliation of seeing patients return time and again to the hospital for what should have been corrected at the first admission.

We expect a diagnosis to be more than a guess. It is an opinion of importance and is to be recorded in the interest of honesty. To be proved wrong in a tilt with the incomparable complexities of disease is no disgrace, but to be faced with a record of error is chastening to the spirit and in the right kind of physician whets the intellect.

What Is Treatment?

Is treatment a votive offering to strange gods or is it a rational application of relief following an opinion as to cause, course, and expected outcome of disease? If it is worth giving or doing, it is worth recording so that it won't be done again if it fails, and to give proof of intelligent endeavor if it is successful.

Disease is no more a fixed condition than is health. Health, is human reaction and, until death, is never stationery. Progress to health or into more desperate disease is human history and if only for historical purposes would be worth recording. That a patient enters a hospital with pneumonia and is recorded as dying under operation for empyema leaves too much to the imagination, and among the imaginings will certainly be the suspicion that the listening ear and the testing hand of the examiner lacked industry in the daily search for explanation of persistent fever, and delayed resolution. In any event the progress from pneumonia to empyema is important to science and if recorded may save the next patient's life.

Then when our worst or best is done, when the patient leaves the hospital a living cripple, a healthy convalescent, or when postmortem examination closes the story, shall we be so glad or so sad that we simply note the final date with no estimate of result, no summing up of experience? Shall we dismiss our friend the patient, knowing well that he knows nothing of the cause or means of preventing a repetition of his digestive, his nervous, his occupational disease? Shall we lose the asset of gratitude, the willingness to learn from those who have helped in sickness, and turn the mother loose with no inkling of the laws of health, the necessary precautions which should see her

through the early months of the baby's life and her own first maternity convalescence?

In such spirit is the true clinical record taken. With all charity and reasonableness let me report what I have found in a study of 1,000 records of patients recently discharged from twenty of the hospitals of a large municipality.

Six hundred and fourteen had something in the way of a personal history of the patient, and of these not more than 200 could be considered a really adequate clinical history. In other instances a recital of the complaints of the patient or simply a statement of the duration of the present illness were considered adequate for the personal history.

In 528 cases there was some entry of the physical examination of the patient, but of these records not more than 350 showed what would be considered as an adequate examination record upon which the diagnosis might properly be based.

A working diagnosis was given in 684 instances.

Laboratory findings, chiefly routine examination of urine, was recorded in 514 instances.

The treatment as indicated by operative procedure or medication was recorded in 717 cases.

Final or corrected diagnosis, that is, condition on discharge or after operation or confirmed or corrected by pathological findings, was recorded in 560 cases.

Four hundred and thirty-four showed a brief statement of the condition of the patient on discharge, that is, whether improved or unimproved or whether death resulted under care.

Progress notes were found in 381 records and this term has been very generously interpreted; in not more than 150 instances did the record include entry of the observations of the visiting physician or surgeon or of the staff as they examined the patient from day to day during the course of the disease.

In only six of the hospitals whose records were studied could the records of patients be considered adequate either for clinical study by physicians in charge of the patient, by the hospital authorities to determine the character of the work they were responsible for, or by students of clinical medicine who might wish now or later to test the experience of others against new scientific facts and theories.

At only four of the hospitals was there any systematic attempt to make a periodic analysis of clinical experience while the contact with the case was fresh in the minds of the physicians, and in only two of the hospitals of the city, was this clinical conference carried out with sufficient detail and completeness to meet the objects of such a professional undertaking.

It must be understood that records should be filed by disease whatever other files and filing indices may be used. And the index card under disease should show the authorship of the record or in other words the physician or surgeon under whom the patient was cared for. A few hospitals in that city have adopted this principle of filing.

Follow-Up of Record Not Done Carefully

The completion of the record before filing is very loosely provided for in most hospitals. The medical responsibility in the case is followed up in most instances if at all by a clerical representative of the superintendent's office. Elsewhere the follow-up is left to a nurse in charge of the record office. Good practice and sound principle would seem to require that the medical staff themselves should provide such oversight of clinical histories and records as

would insure the records being complete in every detail before leaving the ward for the record room, and as promptly as possible after the discharge or death of the patient. The assignment of an assistant on each service to guarantee the professional completeness of history records is valuable insurance against neglect and carelessness.

Where records are typewritten, as is the case in several hospitals, the appearance of the sheets is vastly improved, and where physical examinations and histories are dictated, there is no economy in having the transcribing done by hand.

Physical examination, histories, progress notes, pre-operative, postoperative, final diagnosis, autopsy, condition on discharge, should all be initialed so that the responsibility for the facts recorded or the opinions expressed can be directly traced. It is not thought that there is any real advantage to be gained in the teaching of medicine by the withholding from the student observer, the well considered opinion and diagnosis of physician or surgeon in charge.

Summary Sheet Good for Future Use

Of great convenience for the future use of the histories is what is known and prepared in several hospitals as a summary sheet to be attached to the front of the chart showing the completion of the record with regard to family and personal history, physical examination, diagnosis, progress notes, final diagnosis, postmortem findings, condition on discharge, etc.

In the main, the hospitals apply the same system good or bad for pay, part-pay, and free patients alike, but there are instances where the records of the free patients are far superior to what is entered for the private patients. The presumption that the physician for a private patient has taken a history, made physical examination, and has ascertained the facts usually included in routine laboratory tests may be satisfactory to the hospital, but as a general principle it can be said that irresponsibility and carelessness of method go hand in hand with failure to record observations or to commit one's self to positive findings and opinions. In answer to inquiries which those outside of the hospital circle are bound to ask, namely, are the records sufficient to make possible comparison of hospital method, professional services, and scientific results, we must acknowledge the fact that not more than 25 per cent of the records of patients in these hospitals are taken or kept in such a way as to be of any value whatsoever to the science of medicine or for study of the principles of hospital administration. It is taken for granted that when hospital records are completed and filed they should be accessible to properly accredited workers now and in the future, no matter what their department or the cause for their interest—be it social, medical or administrative.

Endorses Minimum Standard

Briefly I find myself in complete accord in this regard with the minimum standards which have been proposed by the American College of Surgeons—"That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes: the personal history; the physical examination, with clinical, pathological, and x-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available." We should add however a further item,

namely, that before a patient leaves the hospital, he should be instructed by the physician or under the physician's direction by the social worker or other competent adviser, as to the cause of his illness, what he may expect in the future in the way of recurrence, how he may avoid repetition of his malady or infirmity, and such necessary elements of the laws of hygiene and personal conduct as will make the patient his own best protector of his health in the future.

Furthermore I wish to endorse heartily the recommendations of the American College of Surgeons in regard to the periodic analysis of clinical records as follows: "That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analysis."

Nothing Better than Honest Measurement of Work

Nothing more valuable for the betterment of hospital administration and service can be conceived than an honest measurement of failures and successes as demonstrated by the relentless inquiry of a group of fellow workers within the hospital family.

As a warning to those who would exalt records above results, allow me to suggest that the hospital should avoid the danger of developing records for their own sake. There must be due regard maintained as to the value of the records in relation to the other activities of the hospital. The hospital needs not merely to learn results but also to produce results and then keep itself informed as to what these results are. The hospital that merely finds out what results are, may be said to have a "fish-up" system instead of a follow-up system. Learning what the patient's needs are while the patient is in the hospital or what the possibilities of after-care are in the patient's home environment, then making the patient understand these needs and possibilities, are essential factors in producing results, often just as essential as the after-care itself. In other words there should be an intimate connection between the activities of the social service department and the system of finding out the medical results at certain periods after the patient has been discharged. Unless there is such a connection, the follow-up system becomes mechanical and separated from the positive creative activities of the hospital. The social service department should be expected to furnish to the physician facts regarding the home conditions and other items regarding cases which will assist the physician in making the program for after-care. In the second place, the social service department will aid the patient to understand what this program for after-care is, and thirdly it will help the patient to carry out the program effectively. Accurate and complete medical records are indispensable as a basis of the after-care of the patient.

I know of no better investment for the sake of acquiring public credit, hospital self-respect or for meeting the standards of service than requiring and providing for the taking and keeping of clinical records of patients.

Science advances on the back of accumulated facts.

Up to the present time with rare and individual exceptions the information given out from hospitals has been dry and valueless, and may be called the dead ashes of the great repair shops of humanity.

Hospitals report births, deaths, and in general according to their lights and the local enforcement of the law they report notifiable diseases, (preventable, communicable, and occupational, reasonably completely). Public

health administration has moved too rapidly to be served by such reports, and needs now not only the fact of death but the fact of sickness in all cases. No longer do we wait for the death rate to betray an epidemic. We go into the homes and search for the sick on the first suspicion of presence of various diseases and put them, if possible under hospital conditions of isolation. We do not look to the registrar's record of deaths from lead poisoning or enteritis of infants but we send inspectors and nurses to search for patients while they can still be saved.

Malady in Community Needs Early Diagnosis

In other words just as the curability and preventability of tuberculosis, syphilis, appendicitis, diphtheria, and heart disease depend on early and accurate diagnosis, so the presence of a malady in the community must be early recorded if we would prevent and cure community ills.

Briefly, what would be the greatest single addition to the material upon which modern health protection is based? Abundant, prompt, accurate data on the existence and sources of all diseases.

To require this of the individual practicing physician will be impracticable for a long time to come since neither he nor his patients yet appreciate the necessity of reporting even the serious communicable diseases with any great degree of completeness.

Dr. Dublin Suggests Method

Current morbidity data could be supplied by the hospitals as suggested in the chapter on a system of vital statistics for a municipality by Dr. Dublin. (Part II, Cleveland Hospital and Health Survey, pp. 369-371):

"In no American city of any size is it possible to give the total number of cases admitted to hospitals, both public and private, the diseases for which entrance was sought, the age and sex distribution of the patients, the duration of treatment and the result of the treatment. It is a blemish on the excellent work done by hospitals that this phase of their activities has been left undeveloped almost without exception in the United States. . . .

"The necessity for such records of hospital care is never questioned; but nowhere have the necessary steps been taken to assure the receipt of the facts. In the matter of organization, it would be necessary only to establish a central office, preferably in the bureau of vital statistics of the city, where uniform reports would be received from each of the hospitals of the city for each case on its discharge. Such a standard form would include such basic items as age of the patient, sex, color, nativity, occupation, duration of residence in Cleveland, address, diagnosis on admission and at discharge, a brief summary of the treatment, duration of the treatment, the date of discharge and condition on discharge; a statement of the social service work done or contemplated would make a valuable addition. It would be necessary only for the hospitals of the city to agree upon a simple blank including such items as these, and to send them as completed to the central record office immediately upon the discharge of the patient. A nomenclature and classification of diseases and of conditions or states of the patients on discharge should also be agreed upon. . . .

"In the central office these records would be edited and otherwise prepared for transfer to perforated cards which would then be sorted and tabulated by mechanical devices. At comparatively low cost, it should be possible at the end of each quarter and at the end of the year to have available a series of tables showing for each hospital and for all hospitals combined, the essential facts for the cases discharged during the period."

Method Would Permit of Check

The initial suggestion in this field is to be found in the Reprint No. 5 of the Department of Health of New York City by Dr. Charles F. Bolduan, April, 1913, which gives details of a method which would produce invaluable information to permit of a check and estimate of the rela-

tive value of treatments, and a basis upon which an intelligent municipal program could be developed.

Dr. Bolduan however proposed data obtained from a discharge card, while many of the benefits to be expected from hospital reports can come only from a daily record of diagnosis of each case as admitted, with changes of diagnosis as later established.

The discharge card record is perhaps the first step in introducing such a system and the value of this is emphasized also by former Assistant Surgeon General John W. Trask in Public Health Report Supplement No. 12 of April 3, 1914, and by the work of Frederick L. Hoffman in his study of 1913 in the Johns Hopkins Reports.

Other statisticians, including Raymond Pearl, have not only availed themselves of hospital records but have indicated the value in public health work to be expected from further analysis of such data.

Push Inquiry Farther Back

As we have been pushing back the date at which helpful preventive efforts to save maternal and infant life may profitably be employed for the expectant mother, so in an intelligent attack upon sickness we must push our inquiry back towards the date of health and far prior to the death date which is now our index and criterion of results.

Not only hospitals, but dispensaries are in a strategic position which must be used in advancing our knowledge both as to the quantity and quality of sickness, and as stations where the results of preventive measures may be detected.

We talk glibly of health protection, of health leagues, of health departments, and when we analyze their work we find them engaged chiefly in the treatment or alleviation of the end results of disease.

To drop the death rate we split up the reports of deaths into individual causes, and attack our fagot in the old way of the fable by breaking them one at a time, now a big one like infant mortality, now a tiny one like rabies, until the rate has been brought within reasonable distance of a practicable statistical ideal.

Death is often a release not only for the individual but for the community and the dependents. It is sickness, pain, fear, anxiety, that saps human happiness and drops the level of so-called health, which is often merely a label for "being up and about."

Best Source of Information the Hospital

Before we can claim to be developing or even protecting health we must know the sum and character of human sickness. Our first and best and perhaps our last source of information will be the organized medical service shops, the hospitals, and dispensaries, the sanatoriums, convalescent homes and domiciles of the insane, of children, of paupers, and those great institutions now infiltrated throughout the community, the visiting nurse associations, whose experience and records often present a greater range and bulk of material than the larger hospitals of a city or state all combined.

It has been the story of this country that most of the permanent constructive progressive movements in public health have come from private initiative, and later have been assimilated into official policies and administration, and later still have been so approved of as to become incorporated in the sanitary law of the community. It is my suggestion to this association that you authorize a committee on hospital morbidity reports, whose duties shall be at least to enlist the cooperation of some organized hospital group, such for instance as that represented by the Cleveland Hospital Council to the end that uniform

daily reports of admissions, discharges, transfers, deaths, and changes in diagnosis of all hospitalized patients be reported at a central point and there be tabulated and issued at least once a week for the information of the public officers of health and of the practitioners of medicine, and if possible be printed currently in the public press.

It is my belief that in this way necessary knowledge will be promptly available for professional use, and the public will be gradually educated in the true extent, the seasonal occurrence and the occasional formidable proportions of various common diseases.

Confident Would Improve All Medical Work

There would be technical and educational value in the mere mass and currency of the figures, and I am confident that such a system once installed would be found to improve support for all variety of diagnostic, preventive, and curative medical work.

How we have blundered along without it, is hard to see, and once initiated, current hospital morbidity reports will be found as much taken for granted in the scheme of community self-protection as is the weekly report of births and deaths, and of vastly greater ultimate value.

While we now look askance at the states which have failed to meet the minimum civilized requirements of registration laws for human births and deaths it is not unreasonable to expect in the next generation a similar development of public opinion in favor of reports of sickness as it occurs.

Health officers recognize the need, the material is present in abundance, there is lacking only the energy and capacity of a leader among hospital people to take this next step forward. There is no doubt in my mind but that the American Hospital Association will reply as it has always done in the past to each new opportunity for public service. The opportunity awaits you.

WORKING WITHOUT TOOLS

By FRANCES L. GARSIDE, Near East Relief News Service, New York City.

There is no profession that has risen above its handicaps like the medical profession. A carpenter without tools takes a day off, a shoemaker without tools is not a shoemaker, but surgeons without tools are somewhere in the world every day in the year performing marvelous feats of surgery. One has only to look back to the World War to know that.

Of course, these were emergency cases. Sometimes, for days at a stretch, the surgeon had to operate without proper equipment. To do it as a regular thing, however, is more rare, and that is what the physicians and surgeons are doing in the Near East, bringing relief to the patient without the first instrument at hand for doing it. A physician in one of our modern hospitals would throw up his hands in despair if confronted with a patient, and the "kit" used by a practitioner in the Near East.

These men work in hospitals maintained and operated by the generosity of American people through the Near East Relief. Their patients are chiefly among the younger generation; indeed, few mothers and fathers past forty are left. There are younger mothers, girls to whom motherhood is not the joy it proves under happier conditions, and there are many children, suffering from the effects of privation and hardship when driven into exile by the Turks. There are others, whose sufferings are infinitely greater, because the Turks captured them as slaves.

The equipment in these hospitals is not complete, and

the little there is is far from modern. There is no electricity, the sterilizers are heated by oil lamps. New-born babies are cradled in packing boxes, thus, one baby is known as the Coleman's Mustard baby, another as the Royal Baking Powder baby, a third as Crisco, and so forth. The great majority of them are of Armenian mothers, and Turkish or Kurdish fathers. Any day any one of the babies may be claimed by the father, according to Turkish law.

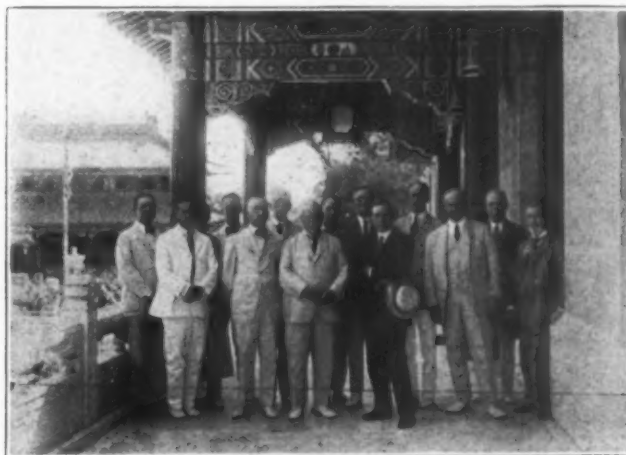
DEDICATE PEKING UNION MEDICAL COLLEGE

The dedication of the Peking Union Medical College, which has been erected and is being maintained by the Rockefeller Foundation in the capital of the Chinese Republic, took place during the week September 15 to September 22, 1921, in connection with an international medical congress and a meeting of the trustees of the college held in Peking. Scientists and delegates from hospitals and medical schools were present from France, England, Scotland, Ireland, Canada, the United States, Japan, Java, the Philippines, and practically every province of China.

Sixteen buildings, including laboratories, hospital wards, out-patient buildings, nurses' home, power plant and auxiliary structures, comprise the institution proper. These buildings, situated on the property of the old palace of Prince Yü, have been erected in Chinese architecture, characteristic of the best of their classic and sacred buildings.

The interiors of the buildings are equipped in the most modern fashion for laboratory, classroom and hospital use. The buildings were started in 1917 and were completed this summer just before the dedication.

The faculty of the school has been assembled from among medical workers who were already in China, from men and women called from other medical institutions in the United States, Canada, and England, and from Chinese trained in Western medicine. This latter group, which already includes a promising number, is expected to increase both in size and in responsibility.



A group of trustees and guests at the dedication of the Union Peking Medical College and Hospital. From left to right they are: Dr. Francis W. Peabody, of Harvard Medical School; Dr. Henry S. Houghton, director of the College; Miss Eggleston, assistant secretary of the board of trustees; Edwin R. Embree, secretary of the Rockefeller Foundation; Prof. Paul Monroe, Teachers College, Columbia University; James L. Barton, secretary American Board of Foreign Missions; Dr. William H. Welch, of Johns Hopkins University; Dr. Richard M. Pearce, director, Foundation's Division of Medical Education; George E. Vincent, president, Rockefeller Foundation; John D. Rockefeller, Jr.; Roger S. Greene, resident director of the Foundation's China Medical Board; F. H. Hawkins, London Missionary Society; Martin A. Ryerson, chairman, board of trustees, University of Chicago; J. Christie Reid, Medical Missionary Association of London.

SOCIAL SERVICE AS RELATED TO OTHER HOSPITAL SERVICES*

BY JANET THORNTON, MEMBER OF STAFF, COMMITTEE ON DISPENSARY DEVELOPMENT, NEW YORK CITY

THAT hospitals and dispensaries exist for the sake of the health of human beings is a commonplace of our faith. Whatever emphasis may fall on particular aspects of their work—such as teaching, research, general and special practice—their great and ultimate purpose is care of the community's health. It is, therefore, the requirements of community health that must determine the essential elements in structure and function of hospital ward or clinic. Fundamental to such conception of health is the thought that health is a dynamic rather than a static process, a condition to be in large measure acquired and achieved (a) by securing things known to be physiological and psychological necessities, e.g., food, oxygen, sleep, movement, warmth, pleasing occupation, companions, obligations; (b) by avoiding things known to be detrimental, e.g., microscopic organisms of various kinds, excesses and errors in foods, over-fatigue, prolonged exposure to heat and cold, thwarted desires and balked energies.

The second thought fundamental to present day conception of health is this—that health is the common interest of all. Typhus fever in Poland is our menace as well as the Poles'. Tuberculosis is passed from servant to master. The breakdown of the family of the injured or exploited worker becomes the burden—and shame—of the community. Care of the community's health means care of all the members.

The third thought fundamental to present day conception of health follows as logical sequence from one and two, viz., that the care of health is a cooperative endeavor. It is neither the privilege of the wealthy, nor the beneficent gift of the wealthy to the poor. It is rather the prime interest of all that it become the possession by right of all.

These three propositions, health to be won, health the common interest of all, health the cooperative endeavor, compel our recognition and assent as self-evident and incontrovertible. And once granting them assent, they lead us a long way—we pass beyond the old hospital of charitable foundation with its limited care for the very few and usually the unfortunate—and face out to a great enlargement of the field of medicine. For medicine has been enlarging in recent decades in quick response to developments in the great underlying sciences upon which it grows—physical, psychological, and social. And as the sciences generate more and greater power to serve, more and greater demands are made upon the medical practitioner for public or communal service, while to hospital and dispensary administrators falls the problem

There are three fundamental propositions in the present day conception of health:

First: Health is a dynamic rather than static state.

Second: Health is the common interest of all.

Third: The care of health is a cooperative endeavor.

Assenting to these propositions we are led a long way from the old hospital of charitable foundation with its limited care for the few, to a greatly enlarged field of medicine. This field has been enlarged during the last decades in response to the development in the sciences—physical, psychological, and social. And with this development there has not always been a clear differentiation between the services of different types. This is essential for an understanding of the relation of social service to other services, and it is this that Miss Thornton has done with remarkable success.

of enlarging and adapting plant, equipment and service to suffice for the demands of modern scientific medicine.

It so happens that most of what we have learned of hospitals and dispensaries has been taught us by administrators of large, complex institutions, where differentiation of function is great and easily becomes rigid, often becomes rigid before functional relationships have been well defined. And yet the original elements in structure and function are not very difficult to find or to comprehend, if we approach the subject with open mind.

The demands as they relate to plant and equipment have been frequently discussed and well defined. Concerning operating personnel or what we might call service department, classification and functions or activities have not, it seems to me, been so well standardized. Now consideration of this service department and its functions is vital to the subject under discussion—the place of social service in hospital and dispensary administration—because social service, rightly understood and practiced, is an integral and specialized part of the hospital's medical service. It is not a generalized hospital service; neither is it a generalized community service injected from without, nor a graciousness contributed by a ladies' committee.

Has Done a Little of Everything

It happens, too, that hospital social service has originated in old, complex, and much organized institutions—Massachusetts General Hospital, Bellevue, Cook County—and has had to face manifold difficulties of adaptation and has followed many leaders in misleading ways. The most frequent and dangerous pitfall has been the attempt to make up for the many inadequacies of hospital management in other divisions of the service department—housekeeping, clerical, financial, nursing, etc.; meanwhile neglecting its own proper and magnificent service, and worse still, obscuring its vision so that it fails to recognize its own place and tries by mere verbalism to appropriate all manner of heterogeneous activities. Yet withal no one knows better or more painfully than the hospital social worker that the kind and amount of every service, social, clerical, administrative, to supplement the physician, so far recognized as adequate by even the best hospital administrators, is very far from adequate to meet the demands of modern medicine.

How may we reach definition and proper coordination of these hospital activities? Will a study of the activities of clinic and ward yield us facts on which to base definition and proper coordination? I feel sure that such a study is one way to the light, and I propose, therefore, to give a somewhat roughly classified list of activities, and thereupon to endeavor to show how self-evident it is

*Read at the Twenty-Third Annual Convention of the American Hospital Association held at West Baden, Ind., Sept. 12-16, 1921.

that many activities supposed to be social are not social, and conversely, that many not supposed to be social are social.

Hospital Activities (Both Clinic and Ward)

Relative to:

I. Government of Institution.

Adoption of aims and objects; creation and direction of policies; appointment of operating personnel; responsibility for product and output of work, for publicity or accounting for stewardship, for general financial management.

II. Upkeep and Operation of Building.

III. Selection, Storage, Distribution, Care of Equipment, viz., furnishings; office and medical appliances and supplies; sterilization and preparation of medical instruments, treatment materials, etc.; care of records, histories, charts, indexes, etc.

IV. Collection and Disbursement of an Accounting for Funds or Moneys.

V. Management of Patients (in respect to body and person of patients).

1. Preliminary or subsidiary to medical work proper and relative to direction and oversight of patients in clinic or ward.

a. Registration or securing and recording identifying data.

b. Classification, social, medical, for assignment to suitable ward or clinic or other medical resources and as to eligibility and proper assessment.

c. Collection of fees.

d. Routing.

e. Maintaining discipline and morale.

2. Relating to medical work proper:

a. Medical (social) investigation and study of each patient.

1. Learning what the patient complains of or believes to be the matter.

2. Observation of patient and his circumstances; from one particular part affected all the way to complete study of organs, systems, functions—with little or much of exact testing (laboratory or other) and little or much of search and insight into personal, social environmental conditions. (Objective symptoms.)

3. Securing from the patient or others familiar with him (as parent with child) a history of relevant circumstances and events in the patient's life, which may consist of no more than a brief statement of circumstances and events immediately associated with complaint, or may be expanded into an illuminating biography covering heredity, development and environmental conditions.

4. On ground-work of evidence afforded by the above processes (1, 2, 3) formulation and statement of the medical (social) problem. (Diagnosis.)

b. Selection and application of remedial measures for medical (social) problem. (Therapy.)

1. Interference with bodily conditions:

Surgical,

Chemical (drugs, etc.),

Bacteriological (vaccines, serums),

Mechanical (Massage, manipulation, supports, etc.),

Electrical,

Radium, x-ray and other ray therapy,

Bio-chemical (foods, gland secretions).

2. Control of Environment:

Protection so that natural defenses of the body may work at best advantage, e.g., rest in bed,

Adjustment and change, e.g., working conditions, recreational opportunities, sanitation, etc.

3. Regulation or change of habits of life and thought, e.g., diet, exercise, apprehensiveness, temper, etc. (Health education of both patient and his community may be included here.)

c. Recording medical (social) investigation and treatment.

d. Analyzing, testing, measuring work done in management of patient. (Statistics.)

A similar listing and classifying might be attempted for hospital relationships covering such topics as convalescent care, public health nursing, schools, courts, hazards and hardships of industry, etc., under a heading "Community Relationships" or of cooperation among divisions of the medical work proper, and administrative control of divisions, etc., etc., and the attempt would yield enlightenment and direction. There is not space for it in a paper of this kind, for it still remains to be shown what in the above list of activities is social in the technical sense of hospital social service and what is not. Furthermore it must be shown how broadly social in a non-technical sense (and the distinction between technical and non-technical or non-medical here is most important), almost all hospital matters are, because inextricably related to community needs. Every item under Section I, "Government of Institution," has social bearing in the non-technical sense, but not one in the immediate responsibility of technical hospital social service proper. Hospital social service has the obligation of supplying trustworthy data and interpreting it to those who are responsible for the governing function, and, therefore, it is obligated to keep correct documents and render correct account of its work.

Not Social Because Done by Social Worker

Furthermore, hospital social service is not directly concerned in any way with Section II, "Upkeep and Operation of Building or Plant," nor with Section III, "Selection, Storage, Distribution, Care of Equipment," nor with Section IV, "Collection and Disbursement of and Accounting for Funds." Hospital social workers may reply that they do nevertheless perform sundry functions under each of the four headings. I myself have done so, but styling myself a hospital social worker and then performing certain acts does not necessarily render those acts social in nature. The verbalistic habit of mind which allows us to describe all the professional acts of a person in accordance with an assumed professional character is easily seen to be absurd as soon as expressed; but is there a hospital in the country that is not describing some house-keeping or social function as nursing because performed by a nurse, some business or clerical function social because performed by a social worker? Like many another intellectual fallacy, its absurdity does not reduce its power for evil.

Not until we reach Section V, "Management of Patients," do we find the activities for which hospital social service is immediately responsible and here, too, there is the interweaving of several functions. Taking up the activities one by one, "Registration or the securing and

recording of identifying data" is plainly clerical in nature. Appreciation of social values, however, makes the clerk realize the importance of this activity, enables him to sense and secure the accurate data, and greatly increases his speed and accuracy by virtue of skill in making contacts with people. Yet registration is not a function of hospital social service. "Classification of applicants as to their eligibility for admission, as to proper assessment of fees, and for assignment to suitable ward or clinic," here for the first time the medical function proper comes into play in securing medical data for proper assignment, and also for the first time the medical-social function in correlating the applicant's medical need, the cost of medical treatment for same, his resources and his obligations. "Collection of fees and routing," c and d, may be briefly described as business or administrative and not medical-social. "Maintaining discipline and morale," e, is obviously social in character. It is the kind of social service, however, that is required in schools, factories, etc.,—when, indeed, groups of people are managed—and is not, I believe, specifically medical-social.

On the other hand, it is plain from the mere rehearsal that the second group of activities under Section V, those relating to medical work proper, contain much that is medical-social. Will it surprise many physicians to be told that much they do is medical-social service? I believe not, though few perhaps ever stopped doing long enough to think the matter out. Most will grant (1) that eliciting from the patient what he complains of or believes to be the trouble is not just a matter of anatomy or physiology, but is also winning of confidence, understanding a personality, etc., and that these last activities are in essence social; (2) that the actual physical examination of the patient requires a technic that is not in essence social, though even here a sympathy with the patient's temperament or rhythm seems to make a strange difference. "The search and insight into personal, social and environmental conditions" is strictly social. (3) Lastly, "Securing from the patient or others familiar with him a history of relevant circumstances or events in the patient's life," is unquestionably a major part in social functioning. It may be concluded, then, that in reaching almost any complete medical diagnosis, social aspects have been considered as causative factors, and some social functioning has revealed the patient.

Passing on to medical treatment, the importance of understanding and managing the personal, social, economic situation of the patient becomes still greater. It is of minor importance in the actual "interference with bodily condition" (Process 1). It is undeniably of major importance in "Control of environment" (Process 2), and "Regulation or change of habits of life and thought" (Process 3). Many illustrations can be brought forward to show that in medical practice of the most tested and standard kind, regulation and re-education of the patient, accompanied by removal of strains from without, constitute almost the whole of treatment; and here again the mere rehearsal of the processes of treatment suggests the importance of social service.

Medicine to Considerable Extent Social

May it, therefore, not be finally concluded that a very considerable part of the practice of medicine has to do with the personal and social life of the patient, much of it with the intimate, often humdrum affairs of every day, and that it is, therefore, right and proper to say that the practice of medicine is to a considerable extent social service?

The thought that medicine should concern itself with

these things is not new; the intention to systematize and organize hospital procedures, so that full consideration shall be given to all social factors relevant to the medical problems of patients, is new or at least so new that a practical procedure for serving all patients rather than a few is only just being worked out. The procedure requires that cognizance be taken of the personal and social as well as the strictly medical conditions and needs of all patients from the moment of application to the hospital, and that the patients shall feel that their individual needs will receive the special care which may be necessary. Social as well as medical record is kept of each case, so that the physician has complete data at hand when summing up for diagnosis and treatment. It is the task of the specialist in social work, collaborating with the physician, to correlate the medical plan with the circumstances of the patient's life and make necessary adjustments.

Make the Patient Help

The general policy pursued is to make the patient a partner in the conduct of his medical care, up to the limit of his understanding, appealing to his intelligence and giving him something to do, and having him do all he can for himself. To follow this procedure it is necessary for the doctor or social worker to tell the patient a good deal about his malady, and to outline at least roughly the plan of treatment, especially as to probable duration and immediate steps to be taken. Furthermore it is desirable and all but necessary to review in detail the relationship of the plan of treatment and the patient's particular plan of life. The mere fact of assisting into clear consciousness all factors of a patient's case, be they helps or hindrances, contributes much toward the solution of his problem. It has been demonstrated that this process of analysis alone gives a fairly high percentage of achievement among people of good intelligence and character, where, without it, among the same people, the percentage is low. Careful talking out, point by point, of each item of the plan, is a great help in getting the patient to understand and see his way clear to carry out the plan. For instance, the medical plan may require the patient to return for treatment too or three times a week over a period of several weeks, or it may require the patient to carry out at home at regular times, certain procedures, such as irrigation, special feeding, rest periods. To adapt or change the day's routine to these therapeutic measures may well call for thoughtful management and sustained effort.

The social worker makes concise entries on a social card of the doctor's recommendations and arrangement for appointments. This card is filed in calendar index under the date of the next appointment and from day to day as the case proceeds. If the patient fails to keep his appointment a letter is sent him, or in more serious cases a visit is paid to remind him and to recall very briefly the plan and instructions talked over with him. The distinction between the interpretative manner of procedure here attempted and a purely mechanical "follow-up" not founded on mutual understanding between patient and hospital is of the utmost importance. Much misunderstanding of the true place and need of the social function in medical work has arisen from describing the mere clerical communication with patients regarding appointments as social work. And whereas the adoption of mechanical devices for follow-up seemed a first step toward social work in some instances, the continued supervision in a mechanical manner only, now appears to me almost more detrimental than absence of supervision, since by missing

the main point of social service in hospital work, the very heart of it—interpretation—it deceives those who practice it and those who support it and thus retards the ultimate socialization of the clinic.

Social Worker Must Overcome Certain Obstacles

Where obstacles for treatment arise greater than the patient can handle unaided, the social worker must decide what resource in the community can give the needed assistance. For example, a district nurse will be asked to watch the temperature and pulse, or give an enema; a vehicle will be secured to bring the sick, old, crippled, or a mother with several small children, etc., back to the hospital; while a few cases will be discovered to need intensive investigation outside the clinic or ward, and organization of extensive relief and corrective measures.

Analysis and classification of the staff or personnel to execute all the activities and procedures above studied can be made to look very simple on paper. In fact, it seems not possible to make more than three big divisions, viz.:

(1) Medical staff,

(2) Assistants or aides to the medical staff,

(3) Administrative staff, together with a governing body, and chief executive or superintendent. Hospital social workers, together with technicians and clerical workers, take their place in Division 2 as assistants to the medical staff. Unless the functions of the three personnel groups are rightly defined, confusion must result. Having defined the functions and learned the technic for their performance, there is no intrinsic reason why one person may not perform many functions. In small institutions, neighborhood clinics for instance, it is often necessary that the executive should fulfill the duties of administration, clerical, nursing, social service and others. Similarly, physicians are many times called on to play the rôle of friend, business adviser, social worker, nurse, etc., as well as practitioner of several medical specialties.

Must Not Neglect Own Responsibility

It may often happen that the social worker in the hospital may be called upon to do things that are not technically hospital social service. Social workers given administrative charge of clinics, for instance, must perform or supervise much clerical work, often business details and even housekeeping matters. The combination of responsibilities is reasonable and it is for the social worker to see to it that she has assistants enough so that the most important responsibility assigned her, viz.: the social service, shall not be neglected. For the social worker must ever bear in mind that the personality of the patient must be reckoned with in nearly all medical processes except those within the laboratory; that the study of character and behavior, the efforts to change habits of thought and behavior, to control environment or in general the social aspects of medicine, are today not usually performed in the systematic, scientific manner of the other more standardized processes of medical work.

Yet a survey of the activities of medical service shows the presence and importance of these elements. If patients are to win health, if the health interests of the community are to be advanced and safeguarded, the social aspects of medicine must be more deeply studied and more skillfully practiced.

Dr. J. N. Hurty, secretary of the state board of health in Indiana, stated at a mass meeting in Lafayette that America is fifteen years behind Japan in public health work. He is in favor of employing an all-time public health officer in cities, and procuring sufficient funds from the legislature to carry on the work on a proper scale.

NEW YORK AS A MEDICAL CENTER

By ALEXANDER H. CANDLISH, Superintendent, New York Post Graduate Medical School and Hospital, New York City.

The reason that the question of medical centers now claims the attention of the medical profession of this country is clearly apparent.

Medical men in America who have been keenly alert to existing conditions in the medical centers of Europe, have long since noted a great decline in their popularity with American students. This decline was observable long before the ravages of warfare had made European cities uninviting to Americans. In fact, it can be definitely stated that the gradual decline of foreign institutions of learning was inevitable, and that the war but hastened the total cessation of their activities.

In former years men of unsurpassed medical ability in this country were ignored by students in the belief that better knowledge in technique in surgery or in physical diagnosis or in one or more of the specialties could be more readily gained in a foreign medical school than from men of ability in equally good institutions at home.

However, it is quite germane to this subject to state that in former years anything foreign was considered superior to what could be obtained at home, this fact being made to refer to the gaining of medical knowledge in particular.

Language and Customs Bar to Education

The average American does not acquire knowledge of foreign languages readily, consequently graduates of medicine on going to Europe were in the majority of cases quite unfamiliar with the language and with the textbooks of the country. Even the manners and the customs of the people with whom they lived added in no small measure to misunderstanding. But the principal difference was the mode and treatment of patients there as compared with the treatment of patients in this country. There the patients were "cases" only, thus adding to the difficulty of obtaining knowledge from these patients. There was also the assumed superiority of the professors not only to the patient but to the student also, thus preventing in many instances an exchange of ideas between professor and student regarding the patients, demonstrated in the class or clinic.

Graduates of medicine and undergraduates went to foreign schools of learning influenced to some extent by the thought that a physician who had studied abroad was considered by his friends, and especially by his patients, to be more eminent and doubtless possessed of much more ability than the surgeon or physician who had received tuition in America. There was also the attraction to foreign clinics created by interesting cases being presented there. This condition is now met at home, and as New York is the gateway to this country, there is a continuous flow of foreigners entering the port, who are suffering from rare diseases, which necessitate their being treated in the hospitals of this city, prior to their being admitted to the country to live or being deported.

Students Will Come to America

The time has passed when comparisons of professors and teachers abroad with professors and teachers at home can be considered, for in keeping with the magnificent growth of this country, our men of science, and especially those of the medical profession, have kept pace, and today there are men in the profession in this country whose reputation in every specialty of medicine and surgery is more than national. This condition recognized, students will remain here and foreign students will come

to America for medical education and for postgraduate instruction especially.

Since the war this country has benefited by the great number of students who have come here from Mexico, South America, and from our various possessions for postgraduate medical education. These men have carried to their homes clearer ideas of American life. The eminence of our teachers, the superabundance of clinical material and the ever-increasing number of large, well equipped hospitals, when made known to others contemplating medical studies, can bring but one result.

In one teaching institution in New York City alone there is a daily attendance of from eight hundred to one thousand outdoor patients, this but attests that no other city at home or abroad has such a wealth of material. When it is also considered that in the one hundred or more hospitals located in Greater New York there are over 28,080 beds, this but makes the attraction to this city the greater.

In addition to interesting material being available, the wealth of the country, New York in particular, has limit-

less possibilities for the erection of institutions of learning. Students will therefore realize that here and not in Europe are the greatest facilities offered in medical education.

Centralization is the thought of the times, evidenced in the centering of large business concerns. The centralization of medical teaching is necessary, and is being suggested by the majority of broad-minded men in the profession. Centralization has been recommended by every survey of medical colleges. Where limited facilities obtain, either in equipment or in clinical material, this is not only unprofitable but unsatisfactory, and as to the question of smaller places being thought of as medical centers, this, for obvious reasons, cannot be considered.

Consolidation has already taken place between a great New York university and a well known hospital. If the affiliation of other institutions continues, the time is not far distant when New York City will offer the most complete facilities for medical instructions to be found either at home or abroad.

HOSPITAL ACCOUNTING AS A BASIS FOR HOSPITAL ANALYSIS*

BY FRANK E. CHAPMAN, DIRECTOR, MOUNT SINAI HOSPITAL, CLEVELAND, OHIO

ONE of the idiosyncrasies of hospital administration is the reaction that is obtained by talking to groups of administrators about their accounting problem. One gains the impression that the recording of hospital performance is looked upon with a great deal of tolerance, in fact, with indifference, and that the problem of properly recording activities is an obnoxious one. The general impression seems to be that the recording of this performance and the analysis of such records is a dry, unpleasant task. One cannot help but believe that this point of view is prevalent because of a lack of understanding of what properly recorded facts mean, and a realization of what intelligent analysis of records will bring to an administrator.

Intelligently recorded figures are far from dry. They furnish a problem of study that is indeed interesting. The sole object of this discussion is an attempt to bring to all of us a better realization of the advantages of proper accounting, and to present the problem so that it may seem less foreboding.

There is only one excuse for the existence of any accounting system. That excuse is that it serves as a basis for analysis. A large percentage of the overhead of commercial activities is expended in proper cost and production accounting. If, in the wisdom of those who have made a success in business, these expenses are indicated, is it not logical to assume that in handling the most precious of all commodities, human life, the same relative degree of expense is warranted in analyzing the performance of a hospital? The various types of accounting that it will be attempted to outline have a very close similarity to the various types of accounting in business.

How often have we been confronted with a request as to certain activities of the institution, and been compelled to answer that while the information is obtainable it will have to be computed? Statistics of any type are of no value unless they are readily available. Statistics of the

financial performance of the institution, to be of value, must be made available within at least fifteen days after the current month has passed or their potentiality for good is lost.

Medical Histories

There is, of course, the ever-present problem of medical histories. There has been a great deal of criticism of the standardization program of the American College of Surgeons. Some say that there has been an attempt made to stimulate paper medicine to the exclusion of the clinical practice, but it is submitted that such an attitude shows an exceedingly narrow point of view as to end results to be obtained, by the proper recording of the medical performance. After all, the medical history and the analysis obtainable therefrom is the production chart of the hospital, and no more careful check should be instituted in the institution than an analysis of our medical performance. It is not contemplated that this article deal with any details of records. This is a problem that must be worked out by each institution. An attempt will be made merely to outline the pertinent requirements, with the hope that with these fundamentals established, institutions may work out their individual requirements as the demand may indicate.

No record is complete unless there is an analysis of results and this analysis made available for commendation or criticism as the performance may merit. It was my privilege to work out and put in actual operation the analysis sheet that is now advocated by the American College of Surgeons, and I wish to emphasize most strongly that the results obtained by the use of this sheet have justified all the time and effort necessary in putting it into effect. I could recite several instances any one of which justified the time and money spent upon it.

The completeness of a history is dependent upon the physical examination, the personal history, statement of present illness, admission diagnosis, operating notes, completely recorded, progress notes, recorded consultations,

*Read at the Second Annual Convention of the Wisconsin Hospital Association, held at Milwaukee, Wis., May 25-26, 1921.

statement of laboratory work, statement of x-ray work, final diagnosis, and condition on discharge. If these things are included in the history, the details of obtaining them and the manner of recording are incidental.

Daily Statement of Vital Performance

All institutions, no matter how small, should maintain a day book of vital performance. This day book may be as large or as small as the institution may desire. The only requisite is that it have at least thirty-two lines, one for each day of the month, and a line for the total. As a concrete illustration, this book may have as headings: Admissions, births, deaths (institutional), deaths (within forty-eight hours), discharges, pay patients, part-pay patients, free patients, total number of patients, number of patients on each ward, number of operations, number of anesthetics, number of x-ray treatments, etc., classification of medical distribution, and in fact any information that is required for current use.

After this book is once set up, it will be necessary to see to it that a statement of the previous day's performance is entered on the proper line today. At any time during the month, it merely means footing a column to furnish the activity for that period. At the end of the month, it merely means adding all of the columns, balancing them out, and transferring them to a page at the back of the book for the year, to give the performance for the month, and to give a one-twelfth basis for the year's performance. At the end of the year, it merely means adding twelve figures in each column to give the hospital's performance for the entire year. Such a book can be maintained in not to exceed thirty minutes work per day in the largest institution in the country, and certainly the results are more than justified.

Financial Records

One of the saddest commentaries in hospital operation today is the attitude of boards of trustees towards their financial records. Most of our boards of trustees are selected because of preeminent success in their personal activities, but when they are elected to membership on a board of trustees, they seemingly forget all of the things that have made them successful in their personal activities, and permit a practice in their hospital that cannot possibly produce the most efficient results. It is hard to understand how an intelligent analysis can be made of a hospital's performance, financially, with the method of bookkeeping that is in vogue in most of our institutions.

A very prevalent practice is that of lumping all salaries spent, under one heading of pay-roll. It would seem that the item of pay-roll means very little in any hospital. The information that is desired is how much of that pay-roll went to administration, how much to housekeeping, how much to dietary, *ad infinitum*. It is recommended that one of the first principles of properly recording hospital finances is to set up a chart of accounts that will reflect the individual departmental performance of the various units of the hospital, so that comparable periods may be analyzed one against the other, to note the performance for those periods. This chart of accounts may be elaborate or simple, dependent entirely upon the demands of the administration, but it is to be hoped that it will not be so simple as to eliminate a basis for computing the cost of various departments. With such a chart of accounts established, then it is incumbent that payments of all types be distributed accordingly.

The same criticism that is made of the method of bookkeeping is made of the financial policy of most institutions. There seems to be the thought that someone will provide, and that we are going to attempt to collect as

much money as we can and spend as little money as we can, and hope that we are going to have enough money to pay our bills at the end of each month. I don't believe that anything can be accomplished unless there is a goal set for that accomplishment, and the only way that I know to create a goal for the financial performance is an absolute adherence to a budget system of accounting.

Income Accounts

We know by our records, or should know, how many patient days' care we should furnish for a given year. We know, or should know, the percentage of these days that are full-pay, part-pay, and free. It will be very easy, at least, I find it so, to compute for each year the approximate earnings for the institution for the year to come. As a specific illustration, if I have twenty rooms that rent for \$5.00 a day, it is reasonable to assume that I will earn twenty rooms times 365 days times 80 per cent occupancy times \$5.00. It is reasonable to assume that I will earn twenty rooms times two operations times 40 per cent operative cases times operating room fee. I can compute any special charges in a like manner. All of this added up will give your earning power for the hospital for the year. This divided by one-twelfth gives the average earning for the month, and may I say to you that the injection of a little spirit of competition into your office force, making them realize that their performance will be judged in part according to their ability to exceed their budget goal of collection, is productive of great good.

Expense Accounts

I am thoroughly a believer in departmental division of expense. I believe that if the dietitian of the hospital knows that she is responsible for the financial performance of her department, that she is going to work harder to live within that budget, and to reduce the number of complaints that she has, than if she feels that she may ask for this and that and the other thing without any set program of performance.

The item of salary is an exceedingly easy one to compute. We merely take the number of our personnel and multiply by their rate for the year and the total of such compilation is the total salary budget. After this budget figure is once set up the department head must realize that he or she must live within that budget.

On the item of supplies, it is comparatively easy if your chart of accounts is properly sub-divided to figure out in actual pounds of commodity or actual yards of commodity, multiplied by an average market price, the amount of money that will be necessary for these supplies. This added together plus a certain percentage for emergencies, divided by twelve gives the average monthly expenditure for each department in the institution.

Confide in Department Heads

There should be no attempt made to conceal true figures from your department heads. Take them into your confidence. Tell them the amount of money that they have to spend. Show them what they are doing each month, and if the spirit of the administration is right, and the intelligence of the department head is proper, you will get a much better result than you could possibly get by a hit and miss financial policy. It is the policy of this institution, that each department head is personally responsible for his financial performance; that the percentage of saving that he effects under his budget, in conjunction with a consideration of the manner in which his department is conducted, is the basis of judgment of his performance, and under normal times there is no reason why every department in the institution cannot live within its budget

provided that budget is properly computed. With such a budget worked out, and with careful watching of the recorded performance, the trail is carefully charted for a successful and efficiently conducted voyage.

I cannot help but reiterate the importance of analysis. If the administrator sets up the machinery of his institution so that these figures will come to him in proper form, and he will really study them with the idea of attempting to discover the weakness of the various performances, he will find them of much more interest than he has thought possible. I must emphasize that this analysis must be made current. Last month's analysis cannot be made three months in the future and be of any value. If it is made

quickly and used intelligently the end results will be ample compensation.

The handling of hospital funds and the operation of a hospital is a sacred trust, and entails a degree of obligation far in excess of the handling of most funds. Communities contribute of their money to hospitals because they have faith in the efficiency of these hospitals, and because they believe that they are assisting in a wonderful work. I believe it is incumbent upon the administrators of hospitals to so conduct their affairs that the trust is not misplaced, and I do not believe that this can be accomplished without an intelligent recording of all activities of the institution.

NURSES' MEMORIAL AT BORDEAUX

AS A memorial to their sister nurses who died in service, the American nurses have erected a building at Bordeaux, France, which will house the Florence Nightingale School of Nursing.

The following cablegram was recently received at National Headquarters of the American Red Cross in Washington, D. C.:

"Bordeaux. Most interesting and remarkable ceremony. Please transmit our grateful recognition to the three organizations. Be assured we shall maintain your standards.—Dr. Hamilton, President Cruse."

The dedication of this building not only serves as a memorial to the brave American women who gave their lives for humanity, but marks an important epoch in the development of nursing in France. So quietly did the nurses go about collecting the money for the building that comparatively few people knew that more than \$50,000 was subscribed for this purpose, most of it by the nurses themselves, through the three large nursing associations—the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing. A few laymen and women who were on the committee on disbursements and transfer of funds, contributed a small part of this amount.

The plans for the school were submitted to the national nurses' organization as well as to the committee on disbursements. They incorporate, in addition to an up-to-date dormitory, the necessary classrooms for the conduct of a modern school of nursing. The perpetuation of the school upon acceptable standards has been indicated by the terms of the gift, and the further assurance from the board of trustees, as witnessed by the cablegram signed by Dr. Anna Hamilton, superintendent of the hospital, and Dr. Cruse, president of the hospital in Bordeaux,

will greatly interest all the nurses in this country.

This school of nursing which now numbers twenty-six pupils was organized eighteen years ago. Mlle. Anna Hamilton, a doctor of medicine, has been superintendent of the hospital and "directrice" of nurses with the assistance of Mlle. Mignot, a graduate nurse, "sous directrice," since the school was established. As soon as she began her professional career, Dr. Hamilton realized that a physician was seriously handicapped without scientific nursing service. Therefore, she concluded to devote her time to the

training of nurses. The result of Dr. Hamilton's efforts is the Florence Nightingale School of Nursing in connection with the hospital, a school which compares favorably with the standard schools of America. The students are young women of education, some of them college graduates, of the best families, and are called upon to meet the most rigid requirements of the standard training schools of any country. They receive education and training in medical and surgical nursing, nursing care of infants and children, and obstetrical nursing. The teaching is thorough and as advanced in practical experience as is possible in a hospital of sixty beds. They learn practical housekeeping, including cooking, elements of pharmacy, and details of the administration of small institutions.

The department of visiting nursing is conducted in a modern, systematic, advanced way, and occupies a most delightful and well planned building, erected by the American Red Cross.

The serious handicap in furthering the advancement of the school has been the lack of a home for the students with the necessary demonstration room for preliminary instruction and the laboratory facilities for practical teaching of the sciences, as well as suitable living quarters to satisfy the needs of the type of student sought. The



Photographed by the American Red Cross.
A view of one of the wards in the Florence Nightingale Hospital in Bordeaux.



Photographed by the American Red Cross.
Children's ward in the Florence Nightingale Hospital.

Rockefeller Institute has given ten scholarships for pupils to receive general nursing education in the Florence Nightingale School, with part of the last year devoted to public health nursing instruction. These pupils have already been selected, and are awaiting admission, but have been delayed because of the lack of room in the school.

Mlle. E. Bosc, an old resident of Bordeaux, learning of the high standard of the school and the work of the hospital, gave to the institution before her death, her estate, "Bagatelle,"—an estate of sixteen acres, just outside of the city limits to be used as a building site, and the grounds for a hospital and a school for nurses. It is believed that Bordeaux can support a 200-bed hospital.

The history of this hospital at Bordeaux is very interesting. It has been operated about fifty-seven years and was built with the particular purpose of caring for all foreign officers and seafaring men, and at the same time meeting the hospital needs of the residents of Bordeaux. There was a great prejudice against such institutions at that time, so in planning the hospital the idea was to erect a building that would suggest a hospital as little as possible. Practically no consideration was given to hospital facilities and conveniences, so the memorial building will fill a long felt need. Over the entrances of the new building, front and back, will be the inscription, "American Nurses' Memorial," while in the large central hall a bronze tablet will be hung giving a detailed description of the gift. Another tablet of bronze, as a memorial to Amabel Scharf Roberts, contributed by the Alumnae Association of the Presbyterian Hospital Training School for Nurses, New York City, will be placed in the library.

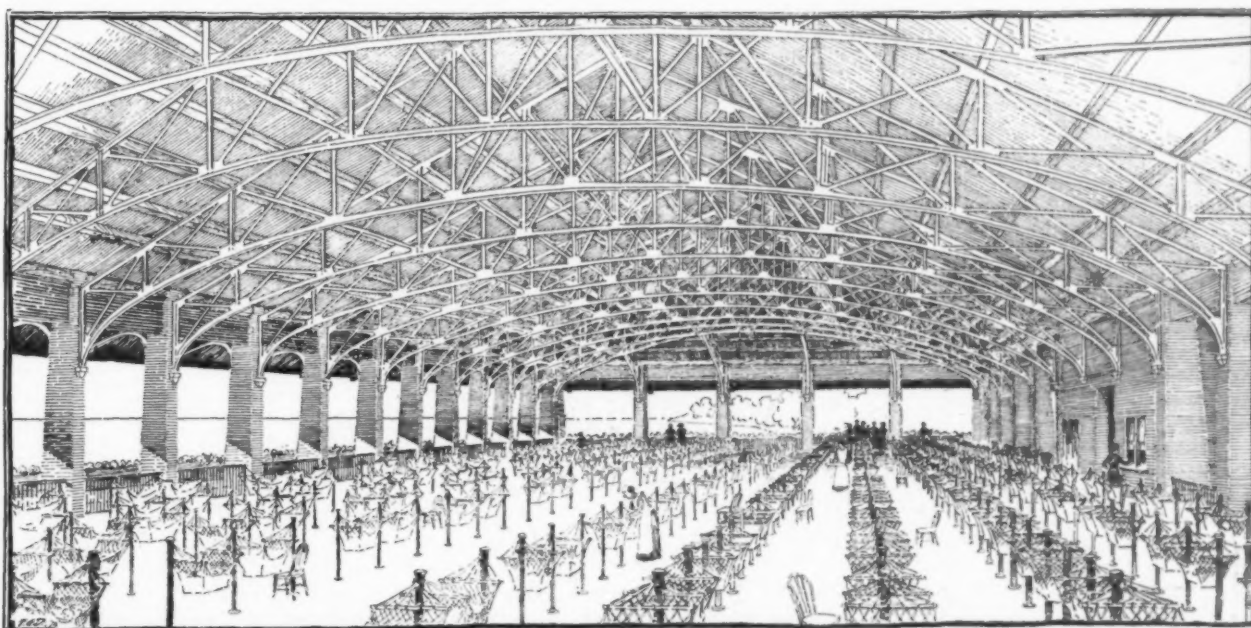
SUNSHINE AND LAKE BREEZES AT THE CHICAGO DAILY NEWS SANITARIUM

"**M**AYBE we've died and dis is Heaven," said bewildered Rosie to no less bewildered little Herman, as they clung to one another's hands and waited for something else astonishing to happen. Then the white figure whom Rosie had quickly classified as "a anjul," said, "No, this isn't Heaven." Then, in an aside, "We bring you here to keep you from going to Heaven so soon." Rosie was more puzzled than ever. Heaven had always been pictured as a wonderful place

with gold streets and lots of ice cream, and the paradox of painting it as the most wonderful place imaginable and then doing all in one's power to keep away from it had never before crossed her mind.

But this was near enough to Heaven. The angel continued, "We bring you here to play all day out there in the sunshine, and at noon you may have all the milk and bread and butter you can eat. Now run along."

They were too numb with wonder and a slow-dawning



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joy to run—but they walked slowly, cautiously, out of the airy building where their mother and the sick baby were sitting talking to a man—angel all in white—out on real grass and on to the very edge of the blue lake. The water was dancing invitingly.

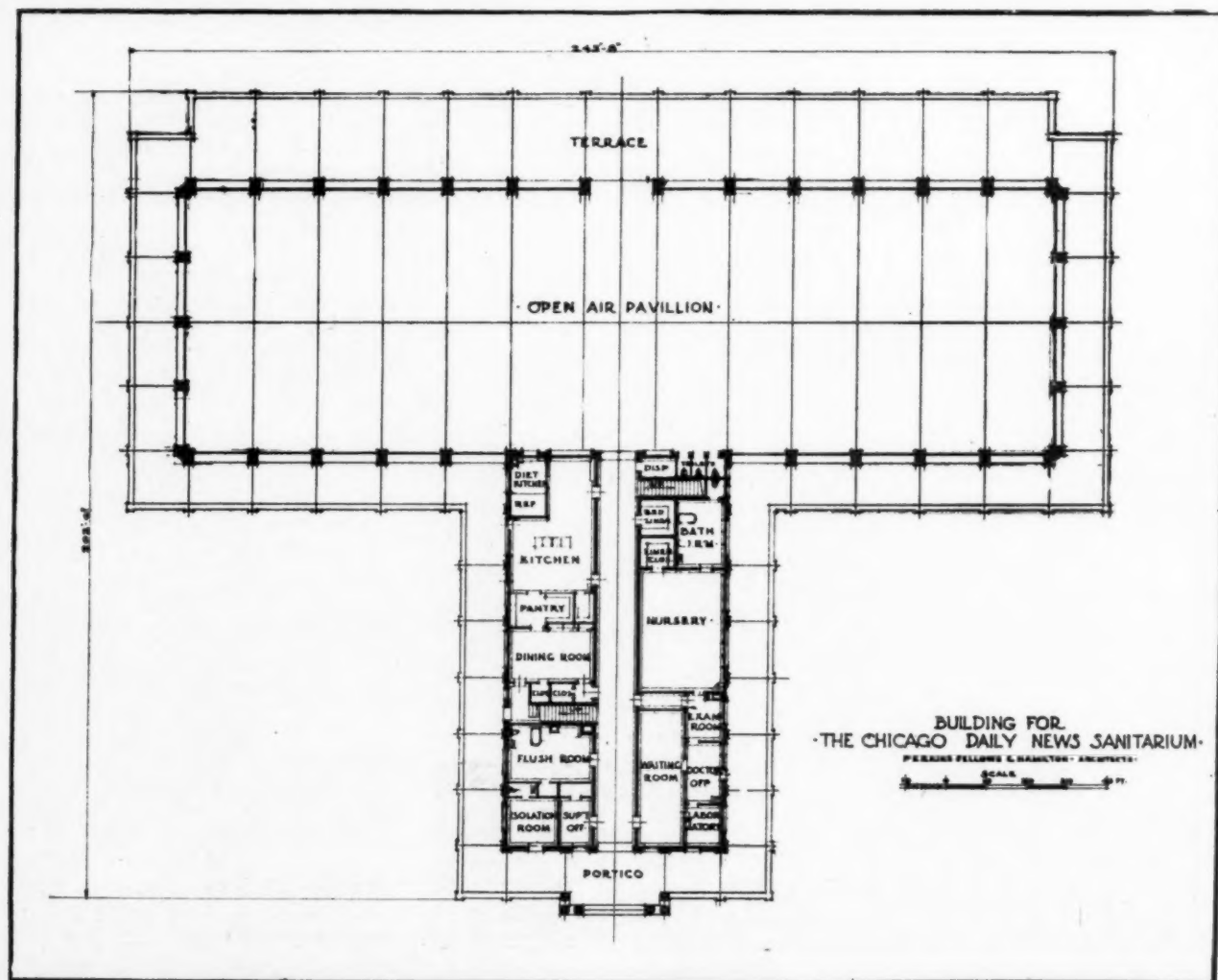
"That's the ocean," said Herman, knowingly. "And over there is China," broke in Rosie, not to be outdone. "No it isn't, it's New York." Just then an aeroplane came into view, flying low over the water. The sunlight flashed on its wings turning them to silver. "That's God in there," whispered Rosie, unable to relinquish her ideas of the celestial sphere.

But, while the older children are turned loose on this enchanted island of breezes and sunshine, their mother, Mrs. Pinsuti, and the baby that "cries all day, he do," are sitting in the long airy hall of the Daily News Sanitarium, on Picnic Island, Chicago, before a white suited intern. Here the ailments are told to sympathetic ears, then as this is the baby's first visit, Mrs. Pinsuti is ushered into the record room where a card is made out, bearing a few instructions for treatment and diet. This is a "season ticket" and is kept by the mother and presented on each visit. Here also the history sheet is filled out. Next the baby is taken to the examination room which is a part of the very complete hospital within a pavilion, or better, the hospital to which a pavilion has been added. This room and the doctor's office are fitted with the best of medicines, thermometers, stethoscopes, and everything that is needed for efficient treatment. The

laboratory, though small, is startlingly white and fitted to make most of the tests which are necessary, although this will have equipment added to it from time to time. The nursery where very sick babies are kept has about thirty little hospital beds, weighing scales, ice caps, and other necessary accessories. When a case is very serious the sanitarium doctors have not the heart to send it home at night and arrangements are made to keep the child and the mother over night—or for several nights if necessary. The superintendent, Dr. R. P. Barstow, hopes to develop this feature until it will be quite possible to keep a good many children over night.

Across the hall from the nursery is another well equipped examination room which can also be used for an emergency room if, as sometimes happens, accident cases from nearby are brought in; a diet kitchen, furnished with refrigerators, filters, milk testers, etc.; and a dining room where the staff, consisting of four interns, eight nurses, and the superintendent, have their noonday meal. There is also a large visiting staff of physicians. Every room is pleasant, clean, and has from its windows a glorious view of sky, lake, and across the little waterway, Lake Shore Drive and Lincoln Park. In the distance, to the south loom the tall buildings of the city.

On the lake side of the building is the pavilion which is a huge porch with graceful arches, which suggest the name given to it by Dr. Barstow, her "cathedral." This is filled with little wire high-sided baskets hung from the ceiling and supplied with comfortable mattresses. Here the



A floor plan of the Chicago Daily News Sanitarium.

babies spend most of the day. There is a drug department opening on to the porch where prescriptions are filled free of charge. On the other side the diet orders which are written out on the baby's card are filled according to the specified interval, mixture, and amount.

Upstairs is a wonderful laundry—not the dingy basement which those women have known by that name, but a cool, light room with stationary tubs, hot and cold water, soap and electric irons—all free. Here many of the mothers do their laundry work while their babies are asleep on the porch. If the children arrive in dirty clothes a few simple clean things are provided, and it is suggested that the mother wash the clothes out in the laundry. This she is usually only too glad to do. First, however, a bath is given to the baby, with instructions to the mother as to how and how often to do it again.

Upstairs also are dressing rooms for the staff, a dormitory for the four nurses who live there, a spacious store room, and a large room of infinite possibilities but whose destiny has not yet been decided upon. It may be used to accommodate the mothers who wish to stay over night with sick children, or possibly for physical therapeutics which is now carried on downstairs in one of the examining rooms.

The basement has a very good furnace which could heat the building adequately even in winter weather, a garbage consumer, and a refrigerating plant which makes the ice for the whole institution.

Dr. Barstow hopes for many things—a full time recreational expert on the terrace, an all year-round service, and expansion, along several lines of the wonderful work which this institution is doing. As one looks around, the



The pavilion is a busy place on hot days.

spontaneous exclamation is "What infinite possibilities!"

During the hot weather of the 1921 season over a thousand people came to the sanitarium a day, about 150 being babies, the rest mothers and children. During the cooler weather the daily average of babies was about forty. Thousands of people whisked away from heat and pavements, and heavy atmosphere, to—this!

But it is time now for Mrs. Pinsuti to round up the reluctant Rosie and Herman and, baby under her arm, to start for the bus. This, the bus which brought them this morning, will take them through the Park and deposit them at a place where they can get the west side car line which will take them directly to their home.

Herman is too happy and sleepy to talk but Rosie is full of the day's happenings, "Ma, we went wadin', and Ma that nice lady talked to us and we"—They are being bundled into the bus but above the clatter of the wheels sounds Rosie's voice triumphantly, "We kin go back tomorrow, kin we Ma? The lady said we could, Ma."

INVESTIGATES CONVALESCENT NEEDS

Miss Mollie E. Sinclair, supervisor of the admission department of the Burke Foundation, White Plains, New York, made a study through the Sturgis Research Fund of the convalescent provision and needs of New York City. The purposes of the study were to determine the most pressing convalescent needs, and how to aid in filling them, either by the addition of new homes or through readjustments and better coordinations in the existing organization. The findings of this investigation are embodied in a little pamphlet reprinted from *Hospital Social Service*, 1921, Vol. 377, which gives some interesting and valuable information.



There is a very complete hospital with thirty beds.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,

Director, Department of Nursing Education, College for Women,
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POPULAR FALLACIES ABOUT NURSING EDUCATION*

BY ISABEL M. STEWART, R.N., TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK

SOME of you have undoubtedly read a recent novel called "Potterism," which is a rather clever satire on our muddled ways of thinking. I'm afraid the great majority of us are inclined to be "Potters"—loose thinkers, refusing to get down to the bottom of things, accepting the conventional view, always tending to twist the truth a little to satisfy our own selfish desires and sentimental fancies, and even where we hold to the truth ourselves, not always courageous enough to defend it before others.

It seems to me that nursing has been one of the greatest sufferers from "Potterism,"—from shallow, shiftless thinking, on the part of not only the public and of our friends the doctors, but on the part of the nurses as well. There seems to be something about the whole question of nursing which makes it difficult to discuss it in a perfectly impartial, rational way. Even people who are trained in scientific thinking and who otherwise seem quite sane and reasonable, will become dogmatic, confused, or sentimental when this subject is brought up. They are apt to be either dead for us, or dead against us, either uncritical champions or unscrupulous opponents. The atmosphere of discussion becomes charged with emotion, and then we are apt to get those electric storms which overflow into the newspapers with their blasts and counterblasts of accusation and protest, personalities and prejudices, everything but clear-cut facts and logical reasoning.

What can we do about it? Many people feel that it is best to ignore falsehoods and let them die out. But the trouble is they don't die. The same old lies go on circulating year after year, and worse, perhaps, are the hazy half truths which often deceive even ourselves. The difficulty is not, as a rule that people intend to mislead or to misrepresent facts, they are simply unable or unwilling to think the thing out straight. If we were more

REBUILD EDUCATION ON NEW LINES

"This is a critical period in nursing education and we must see clearly and build wisely if our work is to stand for the future. The first essential is that we should clear the ground of the old, outworn or unsound timbers which are giving way under the strain of modern demands and the spirit of a new age. Then we shall be better prepared to rebuild our structure, using the best materials and a sounder foundation, fashioning the whole plan on broader lines to accommodate the widely varied activities of our modern profession of nursing. We shall not be alone in this task of reconstruction. In many other fields of work old ideas are being discarded and new experiments are being tried. If we have faith in our work and in the world's need of it, we shall not fail."

familiar with the laws of logical thinking and were determined to trace down every fallacy, to face the facts as they are, whether they are for or against us, and to keep our heads and our tempers, in discussion, we should soon get rid of the dead weights of tradition and misstatement which are hampering our progress; and we should have much stronger support from the public in all our efforts to promote nursing education.

I shall take up only a few of the common fallacies which all of you have heard, I am sure, hundreds of times.

But first let us see what a fallacy is. Those of us who studied logic in the old days remember the historic example: "All men are liars. John is a man. Therefore John is a liar." Without going into the question of major premises and minor premises and all the varieties of error which may creep in, we will remember that fallacies are usually logical conclusions resulting from false or partially true statements, or they are conclusions arrived at from correct facts by a wrong process of reasoning. One of the commonest mistakes is reasoning from the particular to the general; as, for instance, in a statement like the following: "This woman has a college education. This woman is not a good nurse. Therefore, women with a college education do not make good nurses."

Everybody is apt on occasion to draw generalizations from their own limited personal experiences. You are all familiar with the argument that starts this way: "There is something wrong with the training of nurses. Now I had a nurse once—" then follows a long list of individual grievances against an individual nurse for which our whole system of education is indicted.

Old Traditions Difficult to Break Down

The soundest reasoning will make slow headway against a deeply rooted conviction or prejudice which is sanctioned by age or which conflicts with vested interests. The suffragists had their hardest task in breaking down

*Read at annual meeting of Massachusetts State League of Nursing Education, Boston, June 1921.

the age-old tradition that men are naturally superior to women, that women exist mainly to serve the comforts and purposes of men, and that men know best what is good for women, whether in politics or education or domestic life.

I am not sure that this feeling is entirely eradicated yet, in spite of the recent political emancipation of our sex. I am inclined to think that it is still pretty strongly entrenched in the rank and file of the medical profession, and that it tends to color most of the discussions which we have been hearing recently about the function and the education of nurses.

Before discussing some of these questions which involve the medical profession, I want to make it perfectly clear that I have the greatest respect and admiration for medical men (and women) as a group, and a real personal affection for many as individuals. Any criticism which may appear in the following discussion is not directed against the medical profession as a whole, but against certain assumptions and statements which medical men are still circulating and which some of them doubtless believe, but which have, to our minds, no rational basis. These common misconceptions about the relation of nursing and medicine not only cause a great deal of unnecessary friction between physicians and nurses, but misrepresent the nature and scope of the nurse's work in the public mind and keep numbers of splendid women out of the nursing profession.

How many have heard statements something like this? "The nurse is the physician's assistant. She exists to carry out his orders. Therefore physicians ought to know what is the best kind of training for nurses, and should control and direct that training."

Nurses Exist for Service of the Patient

Let us see where the trouble lies in this familiar fallacy. In the first place, I think it will be agreed that nurses exist, not for the service of the doctor, but for the service of the patient and of the public generally. The physician exists for the same purpose. Both are trying to make sick people well, to relieve suffering and to prevent disease. But they have different functions to perform. The doctor diagnoses and prescribes and gives some treatments himself. The nurse cares for the patient's needs, conserves his strength, nourishes him, observes his symptoms and carries out many of the treatments prescribed. Each occupies a different circle, and the circles overlap somewhat. The responsibility for the medical treatment of the patient lies with the physician and there must be no question of divided policies there. The nurse is the physician's assistant in this, but she is much more, for nursing is a distinct art in itself. If anyone doubts, let him remember the conditions of sick patients before Miss Nightingale made her discovery of the laws and methods of modern nursing; or let him study the situation in several countries today, where scientific medicine flourishes but modern nursing is practically unknown. The mortality statistics tell the story.

In many cases of which we all know, the medical treatment is practically nil—it is the nursing which brings the patient through. It is useless to pretend that the physician indirectly brings about this result, that he gives the orders and the nurse simply carries them out. Consider the case of patients in a hospital, the provision for their comfort, their food, light, and air and all the other things which mean so much in recovery, the constant attention to their needs, the observation of changes in their condition, the prompt treatment in emergencies, the handling of all those subtle psychological situations

which so directly affect the total result. How much of this is directly initiated or controlled or even thought out by the physician. It is simply taken for granted and the result too often attributed to medical skill. Or take the visiting nurse whose work in the poorer home, one of our New York physicians calls "a daily miracle." Certainly, she sees that the prescription which the doctor leaves is filled and cooperates with him in every way, but is this all she does before she leaves that home? In addition to actual nursing care, sanitation, domestic economy and assistance to the physician, modern nursing includes a good deal of teaching and social service and community organization. Is this also initiated by the physician? Is it not the outgrowth of nursing, built up and maintained almost entirely by nurses themselves?

Why Should Physicians Control Nurse's Training?

The fact is that the modern doctor knows little more about the details of the nurse's work than the father of a family knows about the management of a household and the care of children. He knows what good nursing is and its results, but he is not skilled in that particular art. He prescribes it as he does massage, or diet, or drugs or dentistry, but that does not mean he himself is skilled in the art of massage, or dietetics, or pharmacy or dentistry. Why should he seek to control the education of the nurse any more than he does the education of the dietitian or social worker or dentist or occupational therapist who also cooperates with him in the treatment of the sick? The physician should be consulted about the nurse's training in so far as it touches on the treatment of disease, and should assist in the teaching of these branches that are distinctly medical in nature. We are always glad to have his point of view about the training of nurses, if it is based on a real understanding of our work. But the job of training nurses must be in the hands of nurses, just as the job of training teachers belongs to teachers. This idea is not new. It is the foundation stone on which Florence Nightingale based her whole system and wherever this rule has been departed from there has been failure.

Is All Nurse's Duty Really Nursing?

This brings us to another phase of the question which has caused heart burnings among a good many nurses and has created a very false idea of the nurse's position in the eyes of the public. Because the nurse assists the physician in certain treatments and because she carries out his directions in regard to the medical care of the patient, is there any reason why she should be expected to act as his personal attendant and wait on him hand and foot? The simple little phrase "follow the doctor's orders" has been interpreted in many cases to mean excessive demands on the nurse's service for things which have little or no relation to the patient or to nursing work at all. The terms so commonly used in hospitals, "waiting on the doctors" or "working for Dr. So and So," shows to what extent nurses themselves have accepted this idea. Let us be quite frank about it. Is all this fetching and carrying really nursing? Does it help the patient or does it take from the time required for his care? Does it add to a nurse's self-respect or help in attracting the better type of young women into our work? Would it be entirely dangerous and revolutionary if, at present, when nurses are so overburdened with the care of patients, we should try the experiment of allowing physicians (especially the younger ones) to wait on themselves a little more? It is being done in families with pretty good results. The old type of domestic autocrat who used to have a whole retinue of

women folk dancing attendance on him, is fast disappearing and the relations of men and women are all the better for it. People used to say that if we got rid of the word "obey" in the marriage service, it would destroy the harmony of married life. But has it? Would it destroy the best kind of cooperation between doctor and nurse if we decided to call the nurse a "partner" or a "colleague" of the physician and treat her as such?

Modern Woman Wants to Use Her Brains

The modern young woman wants to preserve her own individuality in her professional life just as she does in married life. She does not relish the "humble handmaid" attitude. She is not willing always to shine in the reflected glory of someone else. She likes to use her own brains a little now and again and to feel that she has some contribution of her own which is recognized as hers, not as a by-product of some one else's achievements. Is this unreasonable or unnatural?

One would gather from many of the newspaper articles and graduating addresses one reads and hears that there is not much premium put on intelligence in nursing. I heard an eminent Boston physician say a few years ago, "The nurse is the extended hands of the physician." (No brains necessary, you see—she has a motor function merely.) Another of our well-known New York physicians in a graduating address said to the group of nurses, "Remember the nurse is only the private; the doctor is the officer. It is not for her to question. It is for her to obey." In a recent report I found this interesting comment on our educational system: "The nature of a nurse's work as ordinarily understood does not call for much initiative or independent judgment; on the contrary, she must learn to carry out instructions. There are certain inhibitions which must become a part of her professional consciousness and behavior if she is to prove successful in her bedside work."

High Grade Morons Would Do

Is it true that nurses do not need to know or to think, only to tread a routine path which is laid out for them by someone else? If so, we do not need to look much farther for an explanation of our present scarcity of candidates. High grade morons would do quite as well as high school graduates, and we ought to make it perfectly plain to any intelligent young woman who wishes to enter the nursing field that her hands and feet will be needed and the lower centers of her brain and spinal cord, but the rest of her brain might as well be put in cold storage.

As a matter of fact, we all know that nursing does require brains and good brains; that there is ample opportunity in any good nursing school to develop one's faculties of judgment and initiative, and that doctors, whether they admit it or not, rely tremendously on the nurses's judgment—(they usually call it commonsense)—and on her ability to do the right thing at every turn of a constantly changing situation. But why not come out frankly and say that the nurse is the doctor's team-mate and not an automaton; that doctors and nurses need to pool all the brains they have to do the right thing by their patients, and that nursing schools as well as medical schools should aim to bring out and develop the intelligence and initiative of their students rather than to repress it.

Industrial experts are just beginning to realize the tremendous loss of working energy which has resulted from the present autocratic system of management in industry as well as the loss to the individual himself from the crippling of his faculties and the lack of adequate self-express-

sion through his work. It is interesting to notice that even in military training we are beginning to see an entire change in point of view in relation to discipline. "Theirs not to reason why, theirs not to make reply, theirs but to do or die," may be good poetry but that kind of a person is not in much demand in modern warfare or anywhere else except in tending automatic machines.

The biggest question is whether we have any right to induce any young man or woman to enter any branch of work where they will not be allowed to grow and to have free expression for the gifts of mind and spirit which they bring. If I felt that nursing would cramp a young woman's personality and build up artificial bars to curb her mental powers in their natural development, I should not advise her to go into this field. I cannot accept the idea that there is anything inherent in nursing, any more than in teaching or motherhood which requires a sacrifice of one's intellectual life or a crushing of one's individuality. On the other hand, I know of no branch of work which has greater potentialities for the development of all sides of the individual, provided, of course, one has the taste and aptitude for it. Can we afford to let these old vestiges of military discipline and medieval asceticism repel the best type of young women we have in our schools and colleges today?

I had a personal experience not very long ago in this respect. I have a bright young niece who has always said she wanted to be a nurse. I have encouraged her to feel that this is a very fine thing for her to do. But since she has been at college I have noticed a little cooling off in her desire. She wrote to me recently and enclosed a copy of one of our widely circulated nurses' pledges with this little clause underlined, "I solemnly swear that I will be loyal to the physician under whom I serve as a good soldier is loyal to his officer." And she asked, "Is a nurse never allowed to think or act for herself? This is what I object to in nursing." Evidently her professors and friends have been urging her to give up the idea of nursing, thinking that she would be throwing away a good education and wasting her ability in a purely routine obedience to the orders of others. It took me some time to convince her that we are not all "dumb driven cattle," that we do have a chance to use all our talents in our own field, especially in the newer branches of educational, administrative, social and public health work. The military analogy is I think, unfortunate and misleading. The relationship is not that of officer and private. Should we not drop the phraseology and some of the unmeaning and rather humiliating observances which go with it?

Medical Profession Has Reserved Rights

This brings us to another fallacy, perhaps we should call it a complex, which has broken out repeatedly in recent years. A psycho-analyst would probably find little difficulty in getting at its hidden roots. The argument is rarely stated plainly but it runs something like this: Medical students study anatomy, physiology, bacteriology, chemistry and several other sciences which are essential to medical practice. If nurses study these subjects, they will naturally assume that they may also practice medicine. Therefore, nurses should not be allowed to go beyond an exceedingly elementary knowledge of these subjects. One might assume that the medical profession had obtained the exclusive right of way in the whole field of the biological and physical sciences, and that it had the right to arrest anyone straying beyond the outside margin of this field and to convict her as a sort of professional poacher.

Now, we all know that there are a number of other professions which claim a right to study anatomy, physiology, bacteriology, chemistry, etc., and that they go pretty deeply into these subjects without in any way injuring the practice of physicians. Students in domestic science, agriculture, physical education and a host of other fields derive their principles from one or all of these fundamental sciences. Moreover, students in many of our colleges who have no professional responsibilities at all study these sciences, sometimes for years, for the educational value that is in them. Why should there be such a hue and cry when nurses, who are working constantly in a world of bacteria, who are responsible for the care of all kinds of broken down human machines, attempt to understand the mechanism entrusted to them and the dangers that beset it? Many high schools have better courses in chemistry and bacteriology than have been admitted to some of our nursing schools. Domestic science students who are preparing to teach public school children, know far more about the chemistry of food and the principles of nutrition than nurses who are caring for patients whose lives often depend on the way in which they are fed. Scientific farmers, whose interest is in crops and animals and butter making, have extensive courses in bacteriology, while nurses who are handling contagion every day of their lives are allowed possibly a few hours of lectures and are lucky if they ever handle a culture tube or see a slide under a microscope.

No Other Profession Has Limits Set

No other profession is hampered in this way when it wishes to strengthen its foundations and to extend its knowledge. No one speaks of the dangers of over-education for the teacher or the lawyer or the engineer. Everybody professes to believe that universal education is the surest foundation for a democracy and we boast with great pride of the opportunities for education which are open to all in this country without reserve. And yet, here is one group of people (not a whole profession by any means) which says to another group, "These are *our* subjects. You can't put them into your nursing curriculum (except in homeopathic doses), because if you do, nurses will know too much; it will spoil them; they will be over-trained; first thing we know they will be stealing our practice."

Just what ground is there for this bogey of nurses practicing medicine? We hear of osteopaths and chiropractors and Christian Scientists (who surely never studied bacteriology and anatomy) diagnosing and treating sick people, but how many nurses have ever done it? Who is most likely to assume responsibility for prescribing popular remedies, the average lay person or the average nurse? Does the study of these sciences in a fairly thorough-going scientific way tend to encourage amateur dabbling in medical practice or does it not? If any nurse wants to practice medicine, there is no reason why she should not take a medical course as many women do, but most of us prefer our own job. We think we can do our best work for sick people and for the community as nurses, but we want to be intelligent, competent nurses and we believe that we cannot carry our present responsibilities, or follow up the opportunities which lie before us in our own unchallenged field without sounder knowledge.

Fortunately we have a great body of intelligent people back of us who believe in education and are not afraid that it will ruin our usefulness. They are quite willing to agree with our reactionary friends that "A little knowledge is a dangerous thing," but they add, "The only cure for this is more knowledge." There is a danger, of course,

that we may choose the wrong kind of knowledge for our special purpose, or that we might not balance off our theoretical knowledge with the right kind of practical application, or that we might ignore some other phases of training which are equally essential. But these are details of method which must be worked out. They do not weaken the fundamental argument that nursing is based on a number of sciences, just as medicine and other professions are, that nurses have just as much claim to a knowledge of these sciences as any other group and that unless this foundation is soundly laid, we cannot do our work intelligently or well.

Gradually we shall make people see that nursing is not elementary medicine, or the R.N. a sort of half way house to the M.D. They don't lie on the same track though their lines do run parallel a part of the way. Ambitious young women will soon begin to realize that nursing will carry them as far as they can go along any one of a dozen radiating lines, but that an extension of nursing education does not carry one into medical education, nor does a super-nurse mean a mediocre physician any more than a super-woman means a mediocre man. Eventually the public will realize that people who are recognized authorities in medicine and surgery do not necessarily know everything about nursing any more than nurses do about medicine.

Well Educated Persons Will Go Farthest

There is another fallacy which we hear sometimes from both nurses and physicians, and it is not at all peculiar to them because the public generally is apt to feel the same way about many other branches of education. It is that knowledge (theory, they usually call it), makes people theoretical, while practical work (experience) makes people practical. Another way of putting it: The better your education, the less practical you are likely to be. This idea has existed for many years in industry and in business, but it is fast giving way before the actual achievements of numbers of college men and women who are now in great demand in practical business enterprises. Where rule of thumb workers only are needed, education does not matter so much, but where adjustments have to be made and new ideas developed, the most practical person in the end is the one with the most resourceful, most flexible mind, the one with the most usable knowledge, and with the soundest body of principles. Other things being equal, the person with the best education will do her work more intelligently and safely, will advance more rapidly and will accomplish more than the one with little. She may be a little slower in acquiring skill, that is a matter of practice. She may lack some essential qualities of character or spirit, and in this case she would inevitably fail in any field of work in spite of her knowledge or skill. After all there are three sides to the good nurse, all of them essential, and if any one is weak you cannot get a symmetrically developed product. One is the knowledge or "science" side; one is the practice or "skill" side, and one the feeling or spiritual side which gives us the spirit of service, the sympathy and the social vision required in all good nursing work. The point I want to make is that the strengthening of one's knowledge does not weaken practical skill or nursing spirit—it balances the whole structure. The old adage that experience is a good teacher is still sound but we might supplement it by saying that experience plus organized education is a much better teacher and carries you to your goal much more rapidly and with less waste of effort.

There are many other cherished illusions which we

might find to be equally unsound if we examined into them a little more closely. I have some hesitation in questioning this last one for fear some of you may think it a little sacrilegious. It is one of the corner stones of our faith and though I believe it is fundamentally sound, I think we have used it frequently in a wrong sense and sometimes carried it so far that we have done serious injustice to our students. "The patient comes first," has been almost the first commandment of nursing. It is indeed the primary aim of every hospital worth its name, and nurses have done more than any other group to build that idea into the modern hospital system. But the hospital has assumed a second responsibility which is the education of a body of professional women, and it has admitted students to its school on the promise that they shall be given a fair return for their service in terms of education. We are beginning to wonder if it is possible under our present system to combine these two functions in any satisfactory or equitable way, but if the hospital assumes the obligation should it not carry it through? I am afraid that at the present time it is the student body which usually shoulders the burden and pays for the deficits.

A hospital superintendent told me with great indignation the other day of a dying patient who had been left alone because all the student nurses were at class. The fault of course was the nurses'. "Patients must come first." Do you see where this leads? No one would hesitate to interrupt any kind of educational work to meet a special crisis, but emergencies involving life and death are every day occurrences in hospitals and must be planned for without drawing so heavily on the student's time and strength and undermining her fundamental preparation for her life work. How would medical students get their training if the same rule were applied from the beginning to them.

Students Demand Broad Education

A superintendent of nurses told me not long ago that she feared student nurses were losing their fine old spirit of devotion to the patient. I found that some of them had protested because they had been put in a long service on a chronic ward and had missed a number of things—particularly their pediatric experience. She said very sadly, "They think more of their training than they do of the sick patients." Were they entirely wrong? Were they not justified in asking that their training should be as broad and complete as possible in order that their future service to sick patients might be the better? Besides, are they not paying for their training and should they not get a fair return, even if the hospital has to employ additional service to provide for the care of its patients?

As far as the superintendent of nurses is concerned she is on the horns of a perpetual dilemma, constantly torn between her anxiety for the patients and her desire to do justice to her student nurses. Some adjustment can doubtless be made without sacrificing either, but the question is whether any person can serve both masters with absolute faithfulness.

You will think of a great many other fallacies which I have not time to touch on. For instance, "Better education for nurses means more expensive nursing service; low educational standards mean cheap nursing service." Or this: "The better you educate nurses, the less they will want to do. If you give nurses university training they will be no use for practical work at all." We have abundant proof to confute both these statements, but the

general public is apt to be misled by them as well as some of our own friends who should know better.

Overhaul Old Ideas

It seems to me that we could do no better service for our profession just now than to overhaul all our old ideas and traditions and see how many of them can be justified by facts and by logical reasoning. Then we might collect all the current statements we hear about nurses and nursing and submit them to the same test. Finally we should make a united effort to meet false statements with facts, and fallacies with logical arguments. Don't let us be afraid to admit that we sometimes have been mistaken ourselves, that we have often followed in beaten paths without knowing why, and have accepted the decisions of others about our work because we had not the courage or the will to think for ourselves.

This is a critical period in nursing education and we must see clearly and build wisely if our work is to stand for the future. The first essential is that we should clear the ground of the old outworn or unsound timbers which are giving way under the strain of modern demands and the spirit of a new age. Then we shall be better prepared to rebuild our structure using the best materials and a sounder foundation, fashioning the whole plan on broader lines to accommodate the widely varied activities of our modern profession of nursing. We shall not be alone in this task of reconstruction. In many other fields of work old ideas are being discarded and new experiments are being tried. If we have faith in our work and in the world's need of it, we shall not fail.

HOSPITAL FOR CRIPPLED CHILDREN OFFERS POSTGRADUATE COURSE

Realizing the increasing demand for nurses' training in orthopedics and pediatrics the Minnesota State Hospital for Indigent Crippled and Deformed Children, Phalen Park, announces that it is now offering a course for post-graduates and affiliates. The course covers a period of from two to six months, especially emphasizing physiotherapy which plays so important a part in the treatment of infantile paralysis cases, orthopedic surgery, infant feeding, occupational therapy, dispensary and out-service department. The state hospital is well equipped with all modern and up-to-date appliances and has a capacity of 200 beds. Each department is supervised by women who have had extensive training in their particular line of work. Nurses and hospitals interested may address further inquiry to the superintendent.

GOD MADE A NURSE

He made her heart brave, true, and kind,
And like His mountain streams her mind:

As crystal-pure, yet swift or deep
As where their waters rush or sleep.

Her hands He made firm, tender, skilled;
Their touch with His own pity filled.

And gave, to make His nurse complete,
A sense of humor, wholesome, sweet.

God made a nurse—Thank God!

—Selected.

"Not to offend by the smallest physical act in the performance of nursing procedure, should be the nurse's constant concern."—Aileen Cleveland Higgins.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Director, Dietary Department, Mt. Siani Hospital, New York.

THE MEATLESS DIET

By LOUIS J. FRANK, SUPERINTENDENT, BETH ISRAEL HOSPITAL, NEW YORK CITY

IT IS not the purpose of the present communication to make a plea for a new fad in dietetics. Most likely the foods used by man since time immemorial have been conducive to his health and contentment. An attempt to induce human beings to forego certain food ingredients for esthetic, economic, religious, or humanitarian reasons may have such justification for their exclusion from the dietary. But it is doubtful that there are any physiologic or biochemic reasons for the prohibition of proteins or fats, simply because they are derived from a certain source.

The Brahmins and Buddhists, who believe in the transmigration of souls, cannot, of course, recommend the eating of animal flesh. Nor can the sensitive human being who abhors the infliction of pain to dumb brutes partake of flesh obtained by slaughtering these animals. One cannot argue scientifically against esthetic, ethical, or religious convictions, and as far as the individual goes, these reasons hold. But when blind partisans state that meat is harmful because it causes cancer, for example, the burden of proof lies with them, and they certainly have not proved their point, except in an evidently prejudicial manner. For example, the vegetarians state that because of their abstinence from meat the native Africans do not suffer from malignant neoplasms. They could also have stated that the Eskimos, whose diet is based mainly on flesh foods, are as immune to cancer as the Africans.

Digestible foods, fats, proteins or carbohydrates, if assimilable, are equally nutritious, no matter what their source. Whether protein comes from nuts or chicken or cheese or herbs, it is protein, and if it can be absorbed and metabolized without the formation of toxic by-products, this protein has equal food value. So far as nutrition is concerned, herbs are as good as meat. The Bible says, "And God said behold, I have given you every herb bearing seed which is upon the face of the earth, and every tree in which is the fruit of a tree yielding seed; to you it shall be for meat." This was written a long time ago, but it is still good dietetics.

Meat Not Necessary Scientifically

Scientifically, one cannot say that meat is a necessary ingredient in the human dietary. There are those who are convinced, on the contrary, that meat is not beneficial, or is even harmful. Granted, therefore, that a meatless dietary is as good or even better than one containing meat, why not investigate to see if there are other reasons for or against a meatless dietary?

It must be remembered that in this paper I mean by

the word "meat" the flesh of mammal or fowl, but not of fish.

There are certain reasons why a meatless diet is advisable in a hospital such as ours. Those who are acquainted with the Mosaic Law are aware that it is prescribed in the Jewish ritual not to mix meat and milk and their derivatives. The origin of this custom is based upon the bidding of Moses not to seethe the kid in its mother's milk. Upon this ruling the biblical commentators, the gaonim and the rabbis, etc., have based the whole system of dietetic ritual. Meat may not be eaten with butter. Chicken flesh may not be cooked with milk, or butter, or cream, or cheese. Nor may a utensil that is used for "milk" foods be allowed to serve as a "flesh" container. That is, for example, a knife used for the spreading of butter may not be used for cutting meat. A pot in which meat or chicken has been cooked, or in which a derivative of these foods, as for example, beef fat or chicken fat, has been contained, may not serve for cooking milk or holding cream, etc.

The Beth Israel Hospital, however, was created so that the orthodox Jew may have a haven in time of illness, for whereas the reformed Jew or the Gentile may eat anything that suits his palate, the orthodox Jew will forego health, and life itself, rather than partake of food procured not in accordance with the ritual, or served in utensils, etc., not kept for special kinds of food. In order to please this class of patients it is, therefore, essential that separate kitchens, preparation rooms, dish washing room, sculleries, etc., should be provided which, in a hospital such as ours, means the occupancy of considerable extra space.

From a medical point of view there is nothing inherent in meat that cannot be supplied by fish, milk, eggs, and milk products. The protein, fats, and the little carbohydrates and salts may be easily derived from non-meat and non-poultry substances.

Until recently it was surmised by some that meats are a source of vitamins, but this has been recently disproved by Dr. E. V. McCollum, professor of chemistry and hygiene, Johns Hopkins University.

The prejudice and taste of a majority of the people are, of course, for a meat diet, but not because of any true benefit that they derive particularly from it.

Advantages of Meatless Diet

In a "kosher" institution, the following advantages of a meatless diet present themselves.

1. Religious: Certainty of "koshers."

2. Hygienic: Less space to clean; easier to keep clean with no meat; less odors; less garbage.
3. Administrative: Will cater to all—not only to orthodox Jews; will permit a greater number of dishes; will attract those patients to whom a lacto-vegetarian diet is suitable: nephritis, gastro-intestinal diseases, arteriosclerosis, rheumatism, cardiac diseases, etc.; will attract pregnant women who have some gastro-intestinal, hepatic, nephric derangement, etc.; will attract the great majority of human beings because of the diet; will be able to stock up with canned and dehydrated foods in cheap seasons; the workers, after their meals, will be satisfied to a greater extent than they are now, their stomachs, will not be overloaded, and they will be able to work better.
4. Educational: Will teach people the value of foods properly cooked, etc.; will teach the value of vegetables.
5. Economical:

(1) Saving Space: Kitchen (one room for all diets instead of separate rooms for "meat" and "milk" diets); preparation room (one set of rooms instead of two, for same reason); refrigerating room (not necessary to provide for separate "meat" and "milk" compartments); scullery (one room instead of two); dish washing rooms (one room instead of two); "trebering" room (this room would be necessary to prepare meat in conformity with the Mosaic Laws, and can be saved if no meat is used); serving rooms (none will be necessary, since all can be served direct from the one kitchen); dining room (a better arrangement, permitting grouping around one kitchen, otherwise a corridor is necessary to bring food from each kitchen, depending on the meal); cupboard (only one set needed under the non-meat system).

(2) Saving of Equipment: Cutlery, crockery, glassware, pots and pans, outfit of a complete kitchen, outfit of a complete dish washing room, outfit of preparation rooms, housekeeping supplies, etc.

(3) Saving of Light and Gas: For general illumination, for cooking, for heating.

(4) Saving of Help: No "treberer" needed, fewer kosher supervisors, fewer cleaners, less help required because of the lack of necessity to handle heavy quarters of beef.

Disadvantages Refuted

The following seeming disadvantages may be refuted as noted:

1. Necessity for special cooks, etc.; the entire institution will be managed by experts, and just as it will be necessary to secure expert doctors, expert nurses, expert clerks, etc., it will be necessary to secure expert dietitians and expert cooks.
2. The diet may be unsatisfactory for the help, the doctors, and the nurses; I believe they all will be satisfied with the food properly balanced and prepared by expert dietitians and cooks. If they are not, we will pay them to eat out.
3. No provision for that rare patient who will insist on meat; meat, as well as any other interdicted food, will be served upon prescription of the doctor.

4. Expenses may be greater; I do not agree to this, but should the expense be greater, it will be overbalanced by the certainty of the "koshers," for we are going to a great expense to maintain a "kosher" institution, and if a little more money will make that assurance doubly sure, the additional expense is well worth while. In fact, it is mandatory.

5. Necessity for a small campaign of propaganda to overcome criticism of the ignorant; the hospital will be a teaching institution, and it is just as important to teach good food habits as anything else; in fact, more important.

Lacto-Vegetarian Diet

To us it appeared self evident that a lacto-vegetarian diet which permits the use of fish and fish products can be made well balanced and tasteful. In order to appease the fears of the medical profession and the superstitions and prejudices of the lay public, we decided to obtain authoritative confirmation of our opinion, and

Dr. Max Kahn, director of the department of laboratories of the Beth Israel Hospital, addressed the following letter to Professors F. G. Benedict, Russell H. Chittenden, W. J. Gies, Graham Lusk, Lafayette B. Mendel, E. V. McCollum, and Victor C. Vaughan, the most prominent biochemists, metabolists, and physiologists in America:

I have been asked by the president and board of directors of the hospital to obtain your opinion whether it is desirable to institute a vegetarian and dairy dietary in the wards and pavilions of our hospital.

We are especially interested in this matter from the following point of view. In our hospital strict adherence to the Mosaic dietary regulations is enforced. Now it is very difficult, and at times impossible, to be sure that the religious interdictions are strictly adhered to. If, therefore, we could establish a meatless dietary, the question of the religious ritual would be settled.

We wish your opinion, if you will kindly give it to us, as to whether it is possible to prepare a well balanced

WHY STEAM TABLES?*

Why do we find steam tables in the main kitchen of so many hospitals? In the majority of hospitals food for ward service is transferred directly from the range to a food cart or whatever conveyance is used in taking it to the wards. Using a steam table for this service means one extra handling of food. This is detrimental to the food and consumes valuable time.

The same principle holds for service to the nurses' and doctors' dining rooms.

If the employees' dining room is near the kitchen, and service there is direct, a steam table may be a convenience, but a small or medium-sized table is sufficient.

In fifty-seven hospitals visited during the past year, an appalling number of unused steam tables were seen—appalling when one considers the expense of this piece of equipment and when we think of the amount of unnecessary walking which it implies.

Usually a steam table is placed near the range and in the direct path of travel. All day kitchen employees must walk around it. Even if it is used at all, it is used only at meal times for a short period. Is there not some less expensive and more convenient way of meeting the service to employees' dining rooms?—THE EDITOR.

*This is the first of a series of queries which will be a regular feature of the Department of Dietetics and Institutional Food Service for a number of months, depending on the interest which the questions arouse. Discussion is invited, with a view to summarizing and publishing in later issues of the magazine the opinions of dietitians, hospital superintendents and others.

meatless diet which would also contain the vitamins and salts so necessary for nutrition. Please also take into consideration that fish and fish products—exclusive of the shell fish—would be permissible under our conditions.

Their answers follow:

From Francis G. Benedict, director, Carnegie Institution of Washington, Nutrition Laboratory, Boston, Mass.:

Your problem is not very simple. What is the average sojourn of your population? Are there children? Are the hospital attendants on the same basis? All these points need to be considered.

Milk is almost an absolute necessity for growing children. My good friends at the Battle Creek Sanitarium would, I am sure, assure you that your project is hygienically and physiologically sound.

Looking out for the food accessory substances, I should be quite inclined to feel that your plan was a safe one.

From Russel H. Chittenden, Sheffield Scientific School of Yale University:

In reply to your letter of June ninth, I beg to state that in my opinion it is quite possible, and indeed a desirable thing, for many reasons, to establish a lacto-vegetarian dietary in the wards of your hospital. There is no question in my mind that such a diet can be made nutritious and healthful. I suppose you can supplement it by eggs, if necessary. Further, the addition of fish gives you a wide range. But with vegetables of all kinds, with milk, bread and butter, you have at your command all the necessary resources for a nutritious diet.

From William J. Gies, Columbia University, College of Physicians and Surgeons, Department of Biological Chemistry, New York:

I am satisfied you would have no particular difficulty in maintaining satisfactorily a meatless diet that would be well balanced and satisfactory in all respects, including the necessary kinds and proportions of vitamins and all other necessary nutrients.

From Graham Lusk, Cornell University Medical College, Department of Psychology, New York:

I believe that the lacto-vegetarian diet could be established in any hospital without detriment to the health of the patients. It would be well to provide green vegetables or spinach so that iron could be taken in this form. Of course, as you know, a milk diet was long the only support of typhoid patients.

From E. V. McCollum, the Johns Hopkins University School of Hygiene and Public Health, Baltimore, Md.:

I have not the slightest hesitation in saying that vegetarian diet, supplemented with fairly liberal amounts of milk, is the most satisfactory type of diet than man can take. I do not advise the elimination of meat from the diet because of its palatability, but that it is necessary for optimum well-being I do not believe. The use of fish and fish products can be utilized to accomplish the end of increasing the attractiveness and palatability of the foods almost as well as meats. I feel that you would be entirely safe in adopting this kind of diet and that you would be doing much better by your patients than is now being done in many of the best hospitals in the land, where patients are attempting to recover from wasting diseases or from surgical operations on diets of the cereal, tuber, and muscle meat type. Palatable and attractive as they may be, I feel confident that they are not very satisfactory as human foods when adhered to over appreciable periods.

In case you adopt this new plan I shall be greatly interested to follow its development and to learn whether you meet with any esthetic problems in connection with the feeding of your patients.

From Lafayette B. Mendel, Sheffield Laboratory of Physiological Chemistry, Yale University:

I have given some thought to the advisability of introducing a meatless dietary into your hospital régime, and reached the conclusion that there will be no objection to this upon physiological grounds. Inasmuch as I myself lived upon a diet devoid of meat, fowl, and fish for nearly a year, for purely experimental purposes, and remained in excellent health and vigor during that period, I have no fears regarding the wholesomeness of such a procedure.

If we consider the various aspects of the meat-free régime, the foremost criticisms will probably be as fol-

lows: (a) The ration tends to be low in calories. It is true that on a vegetarian diet the food intake is likely to be reduced for a variety of reasons, because the ration tends to become less palatable than in cookery with meat products. However, with fish, milk, and eggs permitted, as I assume they will be in the meatless dietary, the palatability can be greatly enhanced. As a substitute for meat stock or extract of beef in preparing soups, gravies, etc.,—all of which are so highly prized in a well flavored diet such as your patients are allowed,—I see no reason why the now commercially available extracts of yeast should not be used. In England "Marmite" is sold for this purpose, and the same product is available in this country under the name of "Vegex." These commercial names happen to be familiar to me, but there are doubtless others, and it is not difficult to prepare a well flavored extract of yeast. Incidentally, it is rich in water-soluble vitamins. (b) It may be said that the quality of the protein in the vegetable diet is poor. This can scarcely apply where fish, eggs, milk and its numerous products (cheese, etc.) are surely available, as they can be without violation of the Mosaic dietary regulations. As you well know, even small quantities of "animal proteins" serve to supplement well the proteins of the cereals, etc. (c) There will be no lack of suitable vitamins A, B, C, where milk and cream, green vegetables, fruits, and eggs are used in abundance. Surely meat has no virtues as a source of vitamins except in so far as the beef drippings ("oleo oils") may furnish a small amount of fat-soluble vitamins, such as the egg yolk yields in far greater abundance. Incidentally, inorganic salts will be assured quite as well on the meatless dietary, and there will be no lack of suitable "roughage."

If you have ever visited the Battle Creek Sanitarium you will have noted that life is possible and good health is maintained without the use of meat. I regard the diet there as too bland for your clientele, but I am sure the menus could be greatly improved by additions of further foods such as you are not interdicted from employing. Under separate cover, I am sending a few reprints which are intended to support some of the comments which I have made.

From V. C. Vaughn, University of Michigan Medical School, Ann Arbor, Mich.:

I am quite sure that you would have no difficulty in establishing a vegetarian dairy fish diet. You can easily arrange this so that there will be plenty of vitamins and calories. Other meats and other animal foods are, in my opinion, not essential.

A combined meeting of the board of trustees and the medical staff of the Beth Israel Hospital was held to discuss the question of instituting a meatless dietary in that hospital, and two committees were appointed to investigate (a) the scientific aspect, and (b) the economic aspect of the question. The first committee reported the following resolutions:

"WHEREAS, It is not a mooted question that a diet can be prepared exclusive of meat and meat products that will be well balanced and will contain the vitamins and salts essential to nutrition;

"WHEREAS, Such a diet consisting of milk and its derivatives, of eggs, fruits, vegetables, cereals, grains, nuts, etc., as well as of fish, is highly nutritious and satisfactory both to the palate and the stomach;

"WHEREAS, Such a dairy diet has all the advantages and none of the disadvantages of a meat diet, and

"WHEREAS, From intensive study and by correspondence with the leading authorities on nutrition in America the committee has become convinced of the desirability of a meatless diet;

"THEREFORE, It is the sense of the committee that such a diet is scientifically correct."

The committee on economics reported as follows:

"Conceding that the weight of scientific opinion favors a meatless dietary for patients, the hospital economics and the interrelationship of patient, hospital staff, and a hospital furnishing to patients an exclusive meatless diet present these items for consideration.

"A. The prerequisite of an absolutely hide-bound and properly religious adherence to the Mosaic dietary laws would be greatly facilitated and hospital administration simplified by a meatless diet.

"B. It is understood that, by meatless diet, vegetarianism is not implied, fish, eggs, and milk being included.

"Furthermore, it is understood that a properly qualified chef will be employed, so that the diet furnished shall not only be palatable but also shall contain substitutes made from the meatless foods to take the place of meats.

"C. The saving on initial expense in installation of ice boxes and butcher shops and in the employment of butchers will more than allow for provisions, so that the help, nurses and house staff may, at stated intervals, be indulged in their meat diet outside of the hospital.

"D. As far as the ward patients are concerned, no administration disadvantage presents itself that is worthy of consideration.

"E. Private patients of the Jewish faith can enter no legitimate complaint on a meatless diet during the short period in which they remain in the hospital.

"The committee, therefore, feels that, from the administrative standpoint, no disadvantage will accrue to the staff, to the patients, or to the hospital should the board of directors deem it wise to adopt the proposed measures."

The reports of both committees were adopted unanimously.

The "last word" is never spoken on any subject. I do not mean to say that we have irrevocably vowed to have a meatless diet. At the present time, it seems to us that the benefits of such a dietary are numerous and that the patients will especially derive advantage from it. Those who live and think have the inherent right to "change their minds." As somebody has well said, "Perpetual consistency is only an evidence of mental fossilization." However, we have yet to be convinced that there is any good in a meat dietary for a hospital treating acutely ill patients.

REPORT OF THE DIETETICS SECTION OF THE AMERICAN HOSPITAL ASSOCIATION

The Dietetics Section of the American Hospital Association held its meeting on Friday morning, September 16, at 10 o'clock in the convention hall, with Miss Lulu Graves of Mount Sinai Hospital, New York City, as chairman, and Miss Marion Peterson, dietitian of The Swedish Hospital, Minneapolis, Minn., as secretary. This was the first meeting of this section and Miss Graves in her opening remarks said that the dietitians were very glad to have an opportunity of meeting with the hospital superintendents to exchange ideas.

Mr. Street, of Indianapolis, who was to give a paper on "Food Preservation," missed his train and was unable to be present. Miss Eckman, of the University Hospital, Ann Arbor, Mich., read a very interesting paper on "The Dietitian as an Asset to the Hospital," which was published in the October issue of THE MODERN HOSPITAL.

A general discussion followed Miss Eckman's paper. Mr. Pliny O. Clark, of Denver, said he wished Miss Eckman had discussed further the question of the central serving kitchen as opposed to serving kitchens on the floors. Dr. Munger answered this question by saying that they had tried it in the hospital with which he is connected with the result that the food reaches the patient cold and unpalatable. They had also tried the central dishwashing scheme with success, as they feel that there is less chance of spreading contagion in this way. In

regard to kitchen sanitation, Dr. Munger further said that he had had two epidemics due to kitchen employees, one of diphtheria, the other of small pox, spreading not only to employees, but to patients. Since then they have required all employees to have a thorough medical examination especially for venereal diseases, and they must be vaccinated, have a Schick test, take typhoid vaccine and have their hands examined regularly for infections, and a watch is kept for colds.

Central Serving Kitchen Successful

Mr. Burch, Philadelphia, Pa., said that they have a central serving kitchen, and have had no complaints as to the palatability and temperature of the food served. Miss Young, of Nichols Hospital, Battle Creek, Mich., reported that they have a central serving room in a seventy-five-bed hospital, and all the trays are served in eight minutes, from the time the food conveyor is brought to the floor, and there have been no complaints. Dr. Howland, of the Peter Bent Brigham Hospital, Boston, told of the system they used in their private pavilion where all the diets are served from the main kitchen in the basement and sent on electrically heated carts to the floors, and this plan has proved very successful. He also said that the man who handles the milk, goes to the assistant superintendent to have his throat and hands examined every morning.

Mr. Chapman, of Mount Sinai Hospital, Cleveland, said that they reexamined everyone in their hospital every sixty days, and the employees in the dietary department every thirty days. In regard to the central serving room Mr. Chapman thinks it is a question of adequate transportation and possibility of keeping the food hot. There were other experiences with central serving rooms cited in which the service seemed to be good.

Dr. Howland, at the request of Mr. Test, of Philadelphia, explained further their system of handling milk. They buy pasteurized milk, which is poured from the containers into porcelain-lined dairy vats, and then is poured off into containers for the different wards as called for on the requisition slips. The milk is tested for butter fat, and bacteria count once a week. The nurses handle the milk after it reaches the wards. The head nurse is in charge of the trays as they are served, and the dietitian makes rounds and gives suggestions.

Dr. Wilson, of New York, suggested that the handlers of food in a hospital should be examined as to whether they are carriers or not. Mr. Test told of the method they have for handling milk. They use one-half pint and quart bottles for their patients and ten-gallon containers in their kitchen.

There was time for only one question which was: What should be the proper title and status of the dietitian? Dr. McEachern, of Vancouver, replied that in his opinion, the dietitian should be the "director of dietetics," and should have complete charge of the food including the determining of the kind, quality, preparation and service. There were fifteen or twenty other very interesting questions sent in, but for lack of time it became necessary to close the discussion. The meeting was very well attended and it is hoped that next year more time may be assigned to this section in order to discuss adequately the many dietary topics of interest to both dietitians and hospital superintendents.

Respectfully submitted,
MARION PETERSON, Secretary.

On account of lack of space in this department the "News Items" will be found on page 439.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

HOW TO SELECT HOSPITAL FURNITURE*

BY DUANE WANAMAKER, CHICAGO, ILL.

THE importance of selecting the right sort of furnishings for a hospital can scarcely be exaggerated.

Especially in a day and age like the present when the average man and woman have been taught to expect "service first" in everything pertaining to their welfare, it is practically impossible for a hospital to progress very far or attain any noteworthy standing, unless its equipment is of a very high order. And by equipment, in this particular instance, is meant the furniture which goes into the patient's room and which is placed in corridors, sitting rooms, and other places where its suitability will be put to the test to decide whether or not it offers a maximum of comfort and convenience, and at the same time reflects the correct atmosphere.

That word "atmosphere," by the way, is getting to be more firmly entrenched in the dictionary of successful hospital management, with each passing year. The old-fashioned, gloomy, badly furnished and depressing hospital is rapidly disappearing and the modern hospital is more like a first class hotel than anything else. And why is this true? Because pleasant surroundings and the right sort of "atmosphere" are now recognized as a powerful factor in speeding the recovery of the patient. The right sort of atmosphere can only be attained with the sort of furnishings that will help to create it.

Of course, it is hardly necessary to mention that another thing which has speeded the "better furniture movement" in hospital has been the need for more sanitation and a lowered cost of upkeep, due to the ever increasing cost, and of late the scarcity, of trained workers. This phase of "furniture progress" is taken for granted because there

is probably not a single hospital in the country that does not appreciate the convenience and economy of furniture of as good a quality as it feels it can afford. What some hospitals apparently do not appreciate thoroughly, however, is the value of better furnishings in creating the right atmosphere for the patient and in advertising to the world that the hospital is not the doleful place of misery which too many people picture it to be—a place to be shunned except as a "last resort," but rather that it is a sort of auxiliary to the home, where trained service and expert knowledge, together with a homelike atmosphere, will do the utmost good for the patient.

Hospital Should Be Suitably Furnished

This thought was voiced for me by an official of one of the largest and most modern hospitals in the country, who said: "A hospital should not be a barren, bare, desolate place any more than the patient's home should be that way. But, to continue with the simile, the hospital's

ability to furnish conveniences and luxuries is limited by certain conditions, just as the patient's own home will, generally speaking, reflect the sort of position he holds in the community. If a hospital handles charity cases to a great degree, it can scarcely offer more than cleanliness and comfort, made possible by substantially constructed but simple and inexpensive furniture. On the other hand, if the hospital caters to the type of people who can afford luxuries, I believe in offering them everything consistent with good



Showing the arrangement and furnishings of a typical private room in the Ford Hospital, Detroit, Mich.

hospital management. Naturally, the more complicated your equipment the harder it will be to maintain, because it will take more people and a better than ordinary class of help to care for it. But nevertheless the patient who wants and can afford luxurious furnishings should have them in a hospital, just as he demands and gets them in a hotel. There is no sane reason why this should not be the case, that I can figure out." This same official gave me his ideas in concrete form, as to what constitute the

*The writer of this article wishes to express grateful acknowledgment to officials of St. Luke's Hospital, Chicago; Albert Pick and Company, of Chicago; Berkey and Gay Furniture Co., of Grand Rapids; The New England Furn. and Carpet Co., of Minneapolis, and other friends connected with hospitals and furniture establishments for a host of information used in the preparation of this story of how to equip a hospital properly.

correct furnishings for a hospital, and these ideas, coordinated with some other authoritative opinions which I secured on the subject of modern hospital equipment, will, I believe, prove helpful to any institution about to start up, or considering the installation of new furniture.

First, the furniture for a hospital naturally should be selected, like the furniture for any public building, with a view to the suitability for the use intended. Second, it should be of such materials and workmanship that a maximum of service would be obtained with an economy of upkeep. Third, it should be selected not so much as furniture equipment but as a unit or note in the completed room scheme which, if properly done, should not make it stand out or be noticeable above other things in the complete equipment. In furnishing a hospital room color and form should both be given consideration. It seems that it is best to deal in half tones or quarter tones of color. To be explicit, strictly neutral color effects that will be restful, or at least will not jar the nerves of the most sensitive patient, are preferable. Doubtful carving and other ornamental details should be very carefully handled in furnishing a hospital room, for the reasons just given.

Probably of first importance in equipment of a hospital is the bed upon which the patient must spend most of his hours. Comfort is the first requisite here. There are various satisfactory patented adjustments on the market for lowering and raising the limbs of patients and for providing back-rests, but in general the bed should be basically constructed to provide the utmost restfulness. Iron or brass beds have proven most satisfactory, although a large number of institutions prefer to install steel beds which are obtainable in colors to match the furniture, and which not only fulfill all requirements as regards comfort and economy of upkeep, but also are restful to the eye. The upkeep on brass beds, which a leading hos-

pital uses, has been found to be approximately ten dollars per year. This provides for refinishing at regular intervals and generally keeping the bed in first class condition. The same hospital uses link fabric springs for ward beds and box springs in private rooms. Beds should be at least twenty-eight inches from the floor, so that they can be readily swept under, and also to enable the doctor and nurses to be at ease in giving the patient attention. If casters are provided they should be large ones. It is taken for granted that any bed bought for a hospital should be carefully tested to see that there is no "wobble" or noise to irritate the patient.

Bedside Table Important

A bedside table should be provided in every case, which, if properly constructed, will provide a cupboard for the patient's personal belongings. But if a hospital is handicapped by a lack of funds for giving proper attention to points of cleanliness, it is doubtful if anything elaborate along this line should be furnished. It might be preferable to have merely a small "skeleton" table by the bed to lay things upon which should be either of metal, or wood with a glass top.

The average patient's chair, according to a leading hospital is "an abomination." In fact, it is poorly suited to providing comfort for a sick person. The hospital in question has a well known manufacturer make up chairs according to specification. In general, the chair must first of all be absolutely comfortable, and what is comfortable to the "nth degree" for a well person, testing the chair, is considered comfortable for a sick person. It is difficult, admittedly, to build a chair that will be as well suited to a sick man weighing, say 300 pounds and of a well knit frame as to a short man weighing only 125 pounds, but the general criticism of the average hospital chair seems to be that it is built with a view apparently to pleasing only



The furnishings of the foyer of St. Luke's Hospital, Chicago, Ill., might well be compared to that of a modern hotel.

the light man, of small stature. In connection with this, it may be interesting to quote what a prominent manufacturer says about the easy chairs which they build in large numbers for hospitals:

"Easy chairs for hospital use should naturally be built with a view to furnishing the greatest amount of comfort to the largest possible number of people. Naturally a chair of this type is upholstered. Chairs that we have built along this line have been roomy, first of all, with seats lower than the ordinary ones so that a small person can sit in them with comfort, also so that the seat can be bolstered up with a pillow when necessary. The arms should be flat and restful, they should also be substantial, and should have a sufficient arm hold for the convalescents to raise and lower themselves into and out of the chair. The back should, of course, be high enough for a head rest. Our method of building chairs of this kind has been to upholster them in an inexpensive material and then to make slip covers which fasten smoothly over the chair, and which can be easily taken off and changed. This makes for cleanliness."

There should be near each patient's bed, a nurse's chair which need not be of any special type, except that it should be comfortable.

Screens are another item which, I have found, are often built in a manner unsuited to hospital use. The favorite type in a prominent hospital is a screen with an aluminum frame, and aluminum insert instead of fabric of any kind. Such a screen is substantial, sanitary, and is much lighter than a screen with an iron frame, for instance. Stretchers used by the same hospital are of the four-wheel type with a rubber tire run around the top so they won't bang into and dent other objects, at the same time obviating any jars.

The foregoing has been chiefly concerned with the furnishing of wards which may contain any number of patients. Though it applies to a considerable degree to the furnishing of private rooms, as well, what a Chicago hospital of national reputation specifies with regard to furnishing a private room, in detail, should be of interest. In general, a private room should be outfitted like that in a hotel, offering the patient just as much comfort, and luxury even, as is consistent with successful hospital operation. The bed should be along the same lines as previously outlined, but an added reason may be named here for having it at least twenty-eight inches from the floor. This is to provide for a nurse's cot which can be pushed under the bed on occasion to provide more room, or to give the room a more open and cheerful appearance. The cot should be a simple affair, with an iron frame. In it should be set a box spring, with hair top, and it should be suited to sleeping, or sitting upon in the daytime.

A chair especially suited to invalids, preferably a reclining chair, should also be provided. A bedside table, with cupboard not only for holding the invalid's belongings but also with a receptacle for storing the various small utensils needed by the doctor and nurse in dealing with this particular case, should be furnished. An old colonial or spinet desk in mahogany, is considered good taste and a dresser of the same wood should be an important part of the equipment. Besides the bed table, a center table preferably of gate-leg type is advisable to provide a place for a large vase, books, etc., and to allow the patient and visitors to play cards, etc. A portable lamp also should be furnished. Plenty of comfortable chairs, to match the rest of the furnishings, should be provided for visitors, the number to be determined by the size of the room. The color scheme to be used in the room depends a great deal upon the exposure. It pays to use an enamel finish for walls, but flat finish is used in

some hospitals and considered very satisfactory in every way. A French grey finish for light rooms is preferable, making a soft finish without any glare. For a dark room a light buff color is advisable. All blue tones should be kept well down, if used at all. In rugs plain reds, greens, or blues are good for the reason that they not only wear best but show stains and usage less than do figured designs.

Mahogany, considering everything, seems to be the best sort of wood finish for dressers, tables, etc., for use in private rooms. A mahogany piece of a high grade, while higher priced to begin with, is always cheaper in the long run. Not only is mahogany a good-looking wood, but if properly refinished it will be as good twenty years after its purchase as it was on the day it was bought. Mahogany, by the way, is always a harmonious finish, that goes especially well with brass beds. Furniture concerns making a specialty of catering to the needs of hospitals recommend that all furniture such as dressers, tables, and other pieces of cabinet work should be as free from mouldings, panels, etc., as possible, to enable them to be easily kept clean and dustless. Besides, such articles should have round corners and edges, making them agreeable to the touch, and tending to eliminate splinterings. Still further, it has been found that glass tops for these pieces give great satisfaction. In the use of such tops, the custom



A good type of bureau for hospital use.

has been to bring them out flush with the edges of all pieces rather than to inset them with a moulding, as is done in most hotel work. This is for the purpose of eliminating the joint between the moulding and the glass wherein it is possible for dust and moisture to settle. Smooth knobs for drawers are better than any other kind for a hospital, as they neither rattle, come loose easily, nor collect dirt. In buying dressers, it is the best plan to purchase nothing but dust-proof construction, which means that the dresser has panels between the drawers and on the bottom of the piece. Such construction practically eliminates dust collecting, as it is impossible for it to be sucked up from the floor and filtered through the various drawers as is the case when there is no dust-proof

protection. Casters are hardly necessary on dressers if care is taken to buy only those which are high enough from the floor, so that they can be easily swept under. The drawers of every dresser should be dove-tailed, front and back. When this construction is used each piece of the drawer-construction is fitted into the other piece with joints and glue so that dust does not come through, and also it is practically impossible for such construction to come apart.

Construction Important Point in Buying Chairs

In buying chairs, whether for private rooms or for dining rooms and sitting rooms, construction should be an important point if lasting service is expected. In general, box seat construction with bolted back posts and corner blocks in each corner under the seat is the ideal construction. Seats may be of plain wooden finish and can be used this way, or if desired a cushion may be tied to the back posts, which provides for extra comfort as well as sanitation.

Accepted practice in the modern, up-to-date hospital is for every private room to have a closet, with a special key, and a light to come on when the door opens. Such closets ought to be equipped with a rack and hangers such as the better hotels furnish. Having such closets does away with the necessity of having a wardrobe, which is usually top heavy, and, as a rule, cramped and unsightly. In this connection, wherever possible "fixed" pieces of furniture, where used at all, should be put right into the wall, thereby aiding the cause of cleanliness as well as saving space. Every room should be equipped with a private bath: there should be a total elimination of the wash pan and slop jar.

Smoking and lounging rooms for patients who are in an advanced period of convalescence are properly equipped with tables, following general specifications already given, also with wheel chairs, comfortable rockers, one or more couches—of metal construction previously described—having a raised head-piece, facilities for writing consisting of individual desks of the flat type, with perhaps one drawer, and some arm chairs which may be of wicker with room for pillows. Willow is especially fine for sun rooms and sitting rooms but experience has taught that despite its good looks it is short lived, and hence is not considered the most economical "buy" by any means. Besides, willow is not especially sanitary. Dust collects in the "pores" of the construction very quickly, and is difficult to get out. Some hospitals paint willow furniture frequently but this not only is a laborious and costly operation but also turns out badly in the majority of cases.

Sitting or waiting rooms are a necessary part of the well equipped hospital, and they can be furnished as elaborately as the hospital feels that it can afford. In this connection the fact should not be overlooked that such sitting or waiting rooms which are usually just off the main entrance-way, are, in a manner of speaking, the "face" of the hospital and can do much to inspire restfulness and confidence in the minds of visitors as well as advertising the character of the hospital, as reflected in its furnishings and the general service it renders. Leading hospitals have found it especially advisable to outfit at least one small, and conveniently located sitting room for the use of families who may visit the hospital in a crisis and want some place to consult together or rest while awaiting the result of an operation.

Upholstered Furniture Difficult to Buy

Upholstered furniture, which is used extensively in sitting and rest rooms, and in the main entrance-way of most hospitals of any size, is one of the hardest things in

the furniture field to buy and know when you make your purchase that you are getting a piece of furniture that will retain its good looks and lasting quality. There is probably no article of furniture more beautiful than a handsome upholstered piece properly built, but there is nothing more unsightly or irritating than a bad piece of upholstery, especially of the "overstuffed" variety, which might furnish the utmost in comfort if properly constructed. For this reason, two general rules should be followed in buying upholstery. First, be sure that you are dealing with a house which has a reputation for turning out quality merchandise, and which is prepared to "stand back" of its upholstered goods—this is the best "buying rule" of all. Secondly, do not skimp on the price you pay for your overstuffed furniture. There are probably more "grades," as regards ultimate satisfaction, in upholstery furniture than there are freckles on a guinea egg, and one thing is sure, at least, you cannot get a good piece of upholstery from any house that will meet with your complete approval and satisfy you by its ability to stand usage, unless you are willing to pay a decent price for it. Therefore, it is unwise to go about looking for too much of a "bargain" in this line. In this connection, it is well to bear in mind the fact that repairing satisfactorily a piece of upholstery which was not properly constructed in the first place, is a near-impossibility. When it is fixed in one place, it yields in another, and you are continuously without the use of the article while it is in the repair shop. By mentioning these "pitfalls" there is no desire to give the inference that it is difficult to buy good upholstery. There is plenty of it made, and there are any number of houses which produce and sell it. At the same time, you should be warned against efforts to buy bargains at cut rates which within a few months turn out to be disappointments. In a word, the best is also the cheapest, in the long run.

In going about the purchase of a piece of upholstered goods, one of the best tests is to sit upon it. If it yields so that there seems no limit to its depths, and then springs lightly and quickly up again as you lift your weight it is probable that it is a pretty good piece of merchandise. Such action is the result of springs of high quality, wide webbing and good twine employed in the multiple tying of each spring. Probably the best stuffing material is long drawn hair, the next a mixture of hair and moss, and the next tow. The hair and moss combination usually stands up exceptionally well. In connection with testing the seat, it is wise to take into consideration, however, the use to which you will put the piece. If it is to be placed in a lobby where miscellaneous visitors will give it pretty constant use, do not buy a piece, the seat of which is too soft and springy. In the living room of a home such a seat would be desirable, but in a hospital waiting room or hotel a harder seat is desirable, so that the public cannot too quickly get it to sagging. Though many visitors will use the piece, hardly any of them will have to sit on it long, and therefore will not be inconvenienced if it is a bit hard.

For covering, plain brown or blue leather is recommended. There are leather substitutes obtainable which very closely match up with real leather and which give good service, the initial cost being less, too, however, it is doubtful if the general appearance and "feel" is up to that of real leather. But it is for the individual to decide whether it is worth while to make a monetary saving here at the possible sacrifice of a bit of style. As a matter of fact, tapestry coverings look and wear well, and are considered by many to be better all round than leather, though here again the individual taste must rule in making purchases. Tapestry comes in pleasing shades of

plain toned goods as well as in attractive figures, and as both are good taste there is nothing very difficult about selecting a good pattern. One thing in favor of tapestry is that when worn it can be easily and economically recovered. Leather and leather substitutes, however, are more easily cleaned.

Before leaving the subject of upholstered furniture, it might be just as well to mention one more general point as regards picking out a quality line. If the frame is exposed at any place, look it over carefully. If it appears to be of good lumber and well made, it may be assumed that the piece as a whole is well built, as no intelligent manufacturer will tolerate bad "frames" with a quality piece of upholstery. Incidentally, though a good many people think differently, it is not necessary to buy the so-called "custom made" upholstery in order to get quality. Many reputable manufacturers have so standardized the production of these goods that it is now possible to secure a high grade product at considerably less cost than when it is custom made.

A hospital dining room should conform to the general scheme of the rest of the hospital equipment. A dining table with a metal frame and a heavy glass top has proven satisfactory to a high degree. There is only one bad thing about such a table, that the glass is liable to get cracked unless proper care is taken. Several hospitals find it advisable to use a table with a sani-onyx glass top, and bentwood chairs which are comfortable as well as strong, light, and economical to buy. If a buffet for keeping silverware and linen properly stored, is purchased it should be without ornamentation, should have several roomy drawers, and should be of American walnut or mahogany finish. A mirror is hardly necessary and without it the buffet costs considerably less.

Hospitals being built today endeavor to set aside a space in each ward for a dressing and work room for nurses, which should be equipped pretty much the same as one of the large private rooms for patients, though possibly less elaborately.

Unimportant as it may appear to be, any hospital executive will appreciate the fact that the manner in which the corridors of a hospital are furnished and kept up has a great deal to do with rendering first class service, as well as presenting a clean face to the public. Generally speaking, corridors should be as free from surplus furniture as possible. Some authorities hold that nurses' desks, consisting of a table with drawer or a couple of flat pigeon holes for writing material should rightfully be placed in the corridors just outside of the doorways to wards, and this furniture and possibly a few settees, plain wood finish, placed in suitable positions in corridors should constitute all of the furniture in these connecting passageways. Along all such "pathways" it is considered highly advisable to have rubber tile or linoleum laid, to do away with the clicking of heels disturbing patients. This tiling or linoleum should not cover the entire passageway or ward, but should be in strips on the places where the most walking is done. It has already been stated that rugs which can be taken up and cleaned at regular intervals are preferable for private rooms. If a carpet is used it should not have any border.

The entrance-way, or lobby, of a hospital can be made to play just as important a part in its success as in the case of a hotel, and therefore it is as necessary to have the proper furnishings here as elsewhere.

One of the largest and most modern hospitals in Chicago has its entrance-way equipped to resemble closely that of a hotel, with a big round "desk" facing the door and a roll top desk just inside the rail, at one side for the

assistant superintendent. The superintendent has a private office, furnished like any business office, where he can consult with patients or relatives and friends. While it is not the purpose of this article to deal particularly with hospital methods, except as they are more or less directly concerned with the furnishing of a hospital, it may be mentioned here that the hospital just spoken of has former hotel clerks for its desk at the main entrance, and deems it of utmost importance that each visitor get immediate and courteous attention, as well as that records be kept at hand, in detail, for ready reference. The lobby of this same hospital is furnished with attractive rugs and upholstered chairs and settees to resemble the lobby of a hotel.

ILLUMINANT FOR DARK FIELD EXAMINATION

Until recently it has been difficult to secure proper illumination for dark field examinations. Accessory lamps



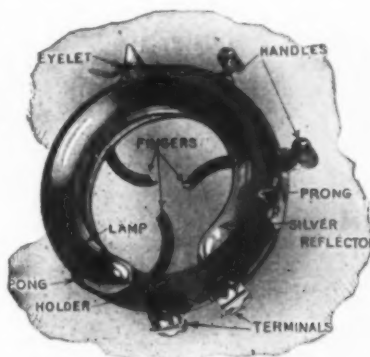
This illumination makes dark field examinations less difficult

were necessary, with results that have not always been satisfactory. A dark field illuminator which is made an integral part of the microscope has now been designed with the cooperation of Major J. B. Foster, Jr., and other officers of the Medical Corps of the Army Medical School.

The illuminant is a low voltage Mazda lamp, mounted in a telescoping sleeve, in such a way that it may be moved to and from the condensing lens in order to focus the light properly. By means of the smaller of two sets of centering screws, it may be centered to the optical axis; larger screws provide independent means for centering the lens system. The apparatus fits the substage ring of all the standard makes of microscopes. The necessary current for the lamp may be obtained on any lighting circuit using a suitable transformer for the alternating or direct current. Storage or dry batteries may also be used.

EXAMINATION OF OPAQUE OBJECTS MADE EASIER

The Silverman Illuminator, which is intended for use in the microscopic examination and photographing of opaque and semi-opaque objects, is the invention of Professor Alexander Silverman, head of the School of Chemistry of the University of Pittsburgh.



An illuminant which is always in place and adjusted because it is raised and lowered with the microscope.

This illuminator consists of a circular Mazda lamp, which surrounds the microscope objective, and furnishes a diffused and uniform illumination on the spot to be examined.

HONEY COMING INTO ITS OWN

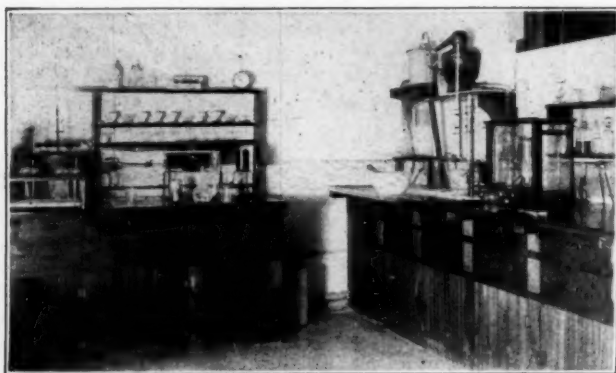
BY GEORGE W. DIAL, MEDINA, O.

HONEY is more than something good on breakfast cakes, biscuits and waffles. It is something good in many forms and combinations, but especially it is something very good for both young and old.

Flowers you pick or gather have the greatest beauty. Foods familiar in their growth and preparation have an added attraction. The romantic details of bee-keeping, the life of bees, their production of honey, their association with sunshine, light and flowers, adds a distinctive flavor to the taste of honey.

Honey cook books list recipes by the hundreds for the use of honey in cooking and baking, drinks and desserts. The present day emphasis on the food value and health value of all foods adds an interest to the discussion of just what honey is and how it comes to our tables.

Due to post-war conditions in foreign countries and exchange rates the importation of foreign honey to the United States has been very heavy. The selling of these foreign honeys in our market has emphasized for the



Laboratory for testing honey as to grade, purity and flavor.

consuming public the difference in quality between the various kinds. Something over two hundred honeys have been chemically analyzed as to their contents, even to the minutest particles of Nature's coloring and flavoring contributions.

Each flower secretes a nectar that provides a honey distinct in color, flavor and consistency. So far as the supply of the flower permits, the busy bee gathers the nectar from one variety exclusively. He does not like mixed drinks and travels many an extra mile to satisfy his taste for an unmixed flavor.

When the children brought word home from school that one pound of honey represented a total winged flight by bees equal to the distance twice around the world, quite a few parents doubted the word. But scientists and naturalists have by experimental tests, proved this statement.

Honey, especially honey in the comb, does come in rather direct "bee line," from the flower to your table. The flower nectar is deposited in the wax comb cells in the hive, and the water is evaporated from it by the high temperature of the hive and the constant ventilation maintained by the wings of bees stationed about the entrance and on the inside. Chemical changes producing honey from the flower nectar result from the original acids in the nectar and from acid added by the bee and to some extent by the wax.

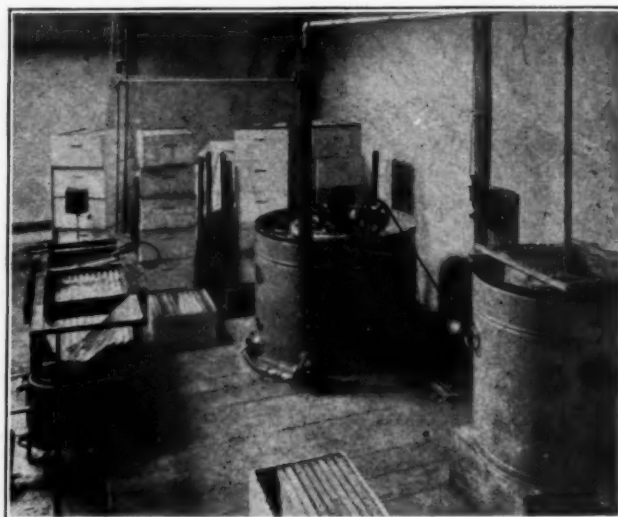
From the hive, comb honey in a wood section comes direct and untouched to the table except for one stop when the section is placed in a wax paper and sealed carton container. Cartons in cases, and shipping cases in specially designed shipping "carriers" insure comb honey against breakage and leakage in transportation.

Liquid honey, commonly known as "extracted honey" because it is liquid honey thrown out of combs by a machine using centrifugal force, also comes to your table unchanged and untouched by human hands. Liquid honey is not honey strained from "mashed-up" honey combs.

Extracted honey is stored in the hive in large honey combs, equal in size to about ten one pound sections. These large combs are made especially for the extracting machines which throw the honey out of the cells. After the cell caps or tops are removed, the honey from the extractor goes through glass lined pipes, to glass tanks, through which it is drawn to automatic bottling, capping and labeling machines.

Each flower produces its own distinctive honey, with its own peculiar flavor and with a color that may be almost any shade of the rainbow. It is this fact that makes differences in the quality and in the price of the honeys offered by food packers. From the tropical countries with their luxuriant flowers strong in color and in scent, we get strong honeys that are not to be compared to our delicate honey flavors known as white clover, basswood, sweet clover, sage and orange. There are certain flowers, it may be noted, though they are very few in number, which produce honeys that are not palatable. The poison honeys contrary to reports are practically unknown. Many of the honeys which are not palatable or are not chosen for table use are used for medicinal purposes and in baking.

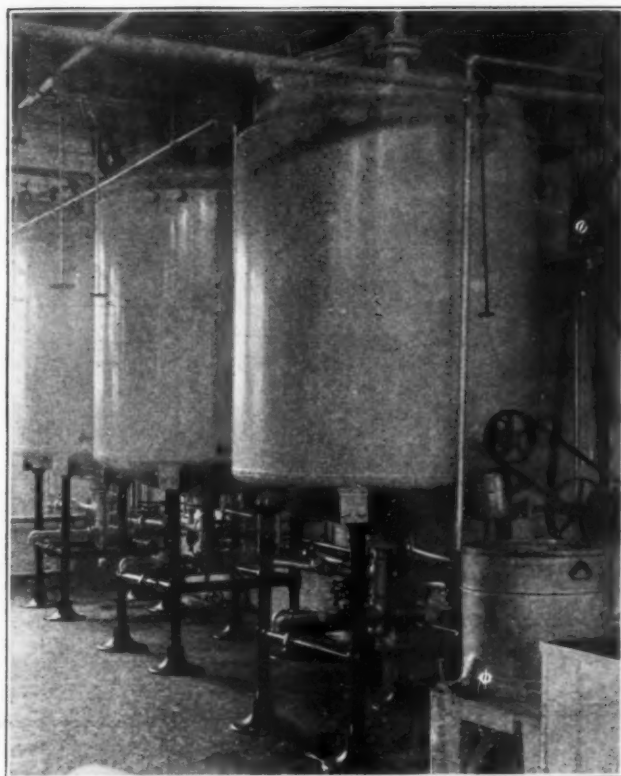
It will doubtless surprise a great many to learn that the secret of their special brand of tooth paste lies in the fact that a component of this paste is honey. Manufacturers of the best brands of candies use very large quantities of honey, not alone for its flavor and sweetening quality but particularly because of the keeping quality which it adds. No other substitute has been found for



Power "extractor" for extracting honey from the uncapped cells. The uncapping table is shown at the left.

honey in this respect, and it is because of this quality that large manufacturers and packers purchase honey in carload lots.

The use of honey by the bakers of fancy baked goods,



Honey blending tanks, holding three tons each.

if it has not been guarded as a secret has never been publicly advertised. If such public announcements had been made it is very likely that the consumption of honey in the home in baking and cooking would be many times what it has been, however, it is growing at a fast pace both for table and kitchen use.

Some food authorities recommend the daily use of honey. These authorities have followed up investigations with the result that they make the following statements:

"An examination of the chart will show that the bread with honey was digested and left the stomach as quickly as the bread alone, although the addition of the honey had practically doubled the food value of the product from the energy standpoint.

"The use of honey with bread and in similar ways would therefore appear to be generally preferable in the case of children to the eating of candies. Honey serves to make the highly nutritious bread more palatable, leading to a greater consumption of body-building foods, instead of depressing the appetite as is likely to be the case with candies which are eaten between meals. At the same time honey furnishes to the body very considerable amounts of energy in the most available form. The high place given to it in the diet is therefore well deserved."

Honey is very helpful to the digestion of both old and young. In Biblical days honey was not considered a delicacy, and it was not used in place of sugar (for at that time there was no sugar to be replaced), but it was used because of its value as a food for good health. It was therefore always classed with milk.

Due to the limited production of honey and because of the increased production of cheaper sweets people until

recently did not consume the quantities of honey which they are now demanding. The food value of honey and the serious effects of a too generous consumption of de-vitalized and manufactured sweets, are better realized today.

The production of honey during the past ten years has more than doubled and there is honey enough for all, honey of the best and the finest grades, at very fair prices, prices that are really cheap when food values of honey are compared with the values in other foods.

NEWS ITEMS FOR DIETITIANS

Miss Florence West has returned to Henrotin Hospital, Chicago. During her absence, Miss Phoebe Mentzer was dietitian at this hospital.

Miss Gertrude Oehning, formerly at Evanston City Hospital, has accepted a position as dietitian at Stuart Circle Hospital, Richmond, Va.

Miss Margaret Hoffman resigned her position at Ohio Valley General Hospital to enter Illinois State University. After a year of postgraduate work at this University, Miss Hoffman will take up the study of medicine. Miss Eleanor Muth succeeds Miss Hoffman at Ohio Valley General Hospital.

Miss Louise Keegan is dietitian at the Montefiore Home, New York. Miss Keegan accepted a position at the Meriden Hospital, Meriden, Conn.; after being there only three weeks, she was asked to take charge of the dietary department at Montefiore and the Meriden Hospital very kindly released her.

A diabetic clinic has recently been established in Vancouver by Miss Esther Kinney. Miss Kinney was for several years dietitian at Vancouver General Hospital, but was compelled to give up the more strenuous work because of poor health. The physicians of the city, and particularly those who are associated with the hospital in which Miss Kinney was dietitian, are welcoming this clinic. Dietitians all over the country will be glad to follow its developments, as it is a movement in which we are all interested.

Does not this schedule of meetings in Boston sound interesting? We greatly regret we did not have a report of each meeting at the time it was held.

REPORT OF THE MEETINGS OF THE DIETITIANS IN BOSTON, 1920-1921. SUBMITTED BY OCTAVIA HALL, DIETITIAN, PETER BENT BRIGHAM HOSPITAL.

November meeting held at Boston City Hospital. Speaker, Miss Josephine Thurlow, Superintendent, Cambridge Hospital, "Teaching Dietetics to Nurses in Reference to State Board Examinations."

December meeting held at Boston Dispensary. Speaker, Miss Bertha Wood, "The Food Clinic at the Boston Dispensary."

January meeting held at Massachusetts General Hospital. Speaker, State Institutional Buyer, "Buying Cooperatively for Thirteen State Institutions." Speaker, Mr. Arthur L. Rowton of Morand-Proctor Company, "Modern Equipment for the Institutional Kitchen."

February meeting held at Parker Hill Public Health Hospital. Speaker, Captain Brown, "The Field Open for Dietitians in Public Health Hospitals."

March meeting held at Corey Hill Hospital. Speaker, Dr. Joel Goldthwaite, "Diet in Reference to Posture."

April meeting held at Mt. Aarat Restaurant. 6 o'clock dinner—only foreign food served. Miss Bertha Wood explained the cooking of this food.

May meeting held at Peter Bent Brigham Hospital. Speaker, Dr. Cyrus C. Sturgis, "Method of Doing Metabolism." "Diets that are used as a result of Metabolic Experiments."

Election of Officers for 1921-1922.

June meeting held at Waltham Training School. All brought supper for an enjoyable picnic.

Officers 1920-1921—Chairman, Octavia I. Hall, Peter Bent Brigham Hospital; Secretary and Treasurer, Margaret Anderson, Cambridge Hospital.

Officers 1921-1922—Chairman, Bertha Wood, Boston Dispensary; Secretary and Treasurer—Elizabeth Tyler, Parker Hill Public Health Hospital.

1. Dr. Philip B. Hawk, Jefferson Medical College, Philadelphia, Pa.

MEETINGS, CONVENTIONS AND CONFERENCES

ALBERTA HOSPITAL ASSOCIATION TO DISCUSS INTERESTING TOPICS

By mutual arrangement of the executive committee of the Alberta Hospital Association and Alberta Association for Registered Nurses it was decided to hold the conjoint annual convention of the two associations at the New Medical Building, University of Alberta, on November 8, 9, 10 and 11, 1921.

It is expected that the meeting will again be of mutual aid and benefit. The convention offers an excellent opportunity to further the chief objects in which the members of the two associations are interested.

It has been proposed that the convention discuss by what means nurses might be equipped as technicians to make elementary laboratory analyses, and to operate x-ray apparatus to meet the demand for these facilities in rural hospitals. It is hoped to arrange a demonstration in laboratory training for nurses, and a report will be given by the committee in charge of the undergraduate nurses' training section on the feasibility of giving all nurses in training a short period at the University.

A memorandum will be presented to the convention suggesting a scheme for affiliation of training schools with general hospitals.

It has been requested that the convention discuss standardization of training pertaining to dietetics for infants, with particular reference to the employment of nurses in the provincial public health and child welfare services. Miss Brown, of Regina, who is recognized as an authority on training, will speak at the convention.

It is proposed to arrange a section of the program dealing particularly with hospital management and finance which will be of particular interest to civilian members of hospital boards and superintendents.

MANITOBA HOSPITAL ASSOCIATION MEETS IN WINNIPEG

The Annual Meeting of the Manitoba Hospital Association will be held at the Medical College of the Manitoba University, Winnipeg, on Monday and Tuesday, November 7 and 8, 1921.

This date has been selected in order to fit in with the annual meeting of the Manitoba Medical Association and thus secure a larger attendance.

The program will consist of short papers on matters of live interest to hospitals, both large and small. Two periods are also being arranged for round table discussion of hospital problems.

Members should be thinking over the problems upon which they desire information. Bring your questions with you, or what is more preferable, mail them to the secretary, so that time may be given to prepare proper replies.

There is a wide field for the Manitoba Hospital Association in a rapidly growing Province such as our own. Such Associations have proved very helpful elsewhere.

While primarily designed for hospital trustees and executives, it is desired that everyone interested in hospital work should attend.

The tentative program is as follows:

Monday, November 7, 1921

- 9:30 A.M. Registration.
- 10:00 A.M. Address of Welcome.
Convention open.
Appointment of Committee on Resolutions.
Address: "The Modern Hospital and Its Community Relations."
George Stephens, M.D., Superintendent, Winnipeg General Hospital.
"The Professional Work in the Hospital—Minimum Standard—Why Records Are Required."
By James McKenty, M.D., Chief Surgeon, St. Boniface Hospital.
- 1:00 P.M. Buffet Lunch at the Winnipeg General Hospital.
Inspection of Hospital.
- 2:00 P.M. Financing the Hospital. The Provincial Act As It Effects the Hospital.
"Hospital Accounting and Purchasing."
By George Stoker, Municipal Hospitals.
- 8:00 P.M. Round Table Discussion of Hospital Problems.

Tuesday, November 8, 1921

- 9:30 A.M. "The Minimum of Training, Education, Equipment for Hospitals Conducting a Training School for Nurses."
By Miss K. A. Cotter, Superintendent, Dauphin Hospital.
"Affiliation from the View Point of the Larger and Smaller Hospitals."
By Miss M. C. McNeel, Superintendent, Children's Hospital.
"The Manitoba Central Nurses' Directory."
By Miss Elizabeth Carruthers, Registrar.
"The Manitoba Association of Graduate Nurses' Act and Proposed Amendments."
By Miss E. Gilroy.
- 12:30 P.M. Visit to Municipal Hospitals, where lunch will be served.
- 2:00 P.M. Annual Business Meeting and Election of Officers.
- 3:00 P.M. Round Table Discussion of Hospital and Nursing Problems.

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR.

Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York

DISPENSARY NEEDS OF A SMALL CITY*

BY S. G. DAVIDSON, SUPERINTENDENT, ROCKFORD HOSPITAL, ROCKFORD, ILL.

ALL hospital people are interested in the establishment and operation of dispensaries. They are interested because dispensaries are such a vital part of hospital service, not only for the work they furnish the staff or the clinical material they may bring into the hospital wards, but because of the great good they accomplish in improving the health, correcting the physical defects, and aiding the needy of the community.

Through its dispensary, the hospital is enabled to give aid to a far greater number of people needing such help, and at far less cost, than any other agency in corrective medical practice. In the light of all that has been written on this very important subject, there is little need, at this time, to go into a discussion of this phase of dispensaries.

Must Be Founded on Definite Knowledge

Those who feel as strongly on the subject as I do will realize that a goodly part of the hospital is missing, if a dispensary is not operated in conjunction with the institution. I believe that, in a general way, we all know or feel that there is a distinct need of a dispensary in our community, or that such a service should be a part of our hospital, that there is work for it to do, that there are people needing such service, and in our thoughtful consideration of our institution, we dream or plan such a service. However, we cannot stop with the idea or the plan, because if we do, years will roll by and the need will not be filled; or, if we go to our staff and board of trustees with the general statement that we think a dispensary is needed and that it would be a good thing for the hospital, and if we make such assertions without being pretty thoroughly conversant with every detail and factor which may enter into the establishment and operation of such a dispensary or without being sufficiently posted to meet every argument which may be raised

Mr. Davidson gives a recipe on "How to Found a Dispensary in a Small City." Probably it would also be applicable to a large city, but it has been tried successfully in Rockford with 70,000 inhabitants. Mr. Davidson first made a survey of the other institutions of the city and found no dispensary in operation. A meeting was then held with the other three active associations of the community who enthusiastically endorsed the proposition, and agreed to help in making a survey of the need. The need was found to be very real. Newspaper publicity was then secured, rooms fitted for temporary use and the first clinic was held. It was a great success and led to the immediate demand for numerous other clinics on special services, which were established as soon as the need was proven. Pay clinics have not been started, for the hospital feels that this dispensary movement, being largely educational, must go slowly if it is to grow surely.

against it in any discussion of the project, we will never have our dispensary, or if it should happen to be installed on the spur of the moment, it will never be a real success.

The establishment of a dispensary must be founded on very definite knowledge of conditions, needs, and methods of meeting them. Within the past three or four months, I have had the opportunity and pleasure of establishing a dispensary in connection with one of three hospitals in a city of 70,000 inhabitants, situated 100 miles from Chicago, the hospital having 110 beds and drawing its

patients from a number of smaller communities within a radius of twenty-five or thirty miles. And the story of what was done and what has been accomplished thus far may be of more practical interest and value to you than any theoretical discussion of dispensaries, their establishment and operation.

In this city, which is a large manufacturing center, there is a working population composed largely of Swedish and Italian peoples, a small percentage of other nationalities, together with the American. The first item of interest in regard to health conditions was the absence of any dispensaries or of any health conservation activities on the part of the city government. There was, however, a state clinic being conducted once each month, more especially for orthopedic cases. As is well known, there is a very distinct sentiment among physicians against state medicine, and as the state health department sent their own doctor from Springfield to examine these cases, some of which were being sent to Springfield for operation, the local men were quite opposed to clinics and this is a condition, or rather a factor, which must be given a great deal of consideration. What is the best manner of overcoming opposition, on the part of the medical profession, in the establishment of outpatient work in small communities? For we have to bear in mind that these doctors are giving a great deal of their time in caring for the poor in their homes. The doctors care for these families when some of the mem-

*Read at the Twenty-Third Annual Convention of the American Hospital Association, West Baden, Ind., Sept. 12-16, 1921.

bers are working and they are paid for their services, and then they are perfectly willing, so they say, to go on caring for the families when the members are not working.

Our next step was to secure information, relative to the mortality rate, and this information was very meager. The baby death rate for 1920 was 80.4 per one thousand births, while the total death rate was 11.76 per one thousand population, both of which were very low, due undoubtedly to good living conditions and to high wages during the war period.

Found Local Need

There are, however, several very active associations, the visiting nurses, the public welfare, the anti-tuberculosis society, and in addition to these, school nursing is being carried on in a manner superior to the average community. After gathering together as much information as possible, I had a long talk with one of our staff members, a leading pediatrician, who also has charge of the school children inspection work. From his knowledge of conditions, among the school children, he felt there was distinct need of dispensary work for babies and children, more especially as there had existed, since January first, a local condition of about 50 per cent unemployment. He felt that many families were beginning to feel the pinch of hard times, that they would not be able to purchase the usual nourishing food, and with the hot summer coming on, a great deal of sickness would exist among babies and undernourishment among the children. We asked for a meeting of the representatives of the three organizations previously mentioned, for the purpose of getting their opinions. In the meantime, we looked over our hospital and found on the ground floor in the older part of the building two rooms, one a corner room, nine by twelve feet, which was occupied by a maid, and next to this a room, twelve by twenty-four. The larger room was being used to store bedding, etc., and was also used as a sewing room. It took only a short time to find a place in the basement for the bedding and also a good sewing room, so we went into the meeting with the knowledge we had the necessary space. The general sentiment at this meeting was unanimous in supporting the opinion of the staff doctor; but it was decided to have a survey made by the nurses of the various organizations to determine whether or not our conclusions were correct. This survey covered every poorer section of the city, and when the reports were turned in, we discovered that conditions were not so acute as we had thought; that men, out of work, were getting odd jobs; that they were drawing on reserve funds; that their gardens were helping them out for the summer; and that there was, as yet, comparatively little undernourishment among children. But we also discovered that families, in their effort to practice economy, were cutting down first on their milk supply. We felt that this would have a serious effect on the health of the children, so it was arranged to buy milk at a very low cost and sell it at the various playgrounds at two cents per pint, and a fund was made available for this purpose. It was, however, brought out very definitely at this second meeting, that families without income would, undoubtedly, be in need of medical service for which they would have no funds.

Hold First Children's Clinic

This meeting, then, developed the fact that there was a real need of an out-patient department for sick babies and children, and that there would probably be found among those children to whom milk would be sold at

the play centers, a few so undernourished as to need the advice of a physician. We, therefore, arranged to hold our first out-patient clinic for children on Monday, June 20. We secured good newspaper publicity, and on that first morning, seventeen children, ranging in age from nine months to fourteen years, were brought in for examination. Of these, twelve were referred by the Visiting Nurse Association and five came of their own accord. Upon examination, we found four to be surgical cases; two, mental; one, eye; and the remainder, feeding cases, three of which were children nine to thirteen, plainly undernourished. Of these seventeen cases, four were transferred to the hospital. At this point, I think it would be of interest to say that we had given careful thought to the out-patient records and had printed a form which we felt would meet every need. We only had fifty made up on the proof sheet and used these at the first clinic in order to discover where we might improve on them. They were made up, too, to fit in with our hospital records.

Our examination room was furnished with all the equipment used in our old emergency examination room and has since been used as an emergency room also. The waiting room was furnished with discarded school room benches. The hospital had never had a children's department, our pupil nurses receiving their children's training in one of the large Chicago hospitals, but late in May we severed our affiliation and recalled our pupil nurses in order to give them their children's training under our own supervision. We had foreseen the need of such a department and had purchased six five-foot children's beds and eight four-foot cribs. On the second floor of the old part of the hospital there was a four-bed ward at the end of the corridor, while outside was a covered porch. We had the porch inclosed with wire screen at a cost of \$38.00 and, with the ward, had room for fourteen children. To this porch ward went the four feeding cases, two clubfoot cases, one congenital hip case, one poliomyelitis case, and one tuberculous spine.

Physicians Start Record Keeping

You may be sure this was a red letter day at this hospital, for it was also the beginning of record keeping on the part of the physicians, and the opening of a fully equipped laboratory in charge of a Class A pathologist, and our doctors were considerably keyed up. Every staff man who came in had to go back and see the laboratory and out-patient department. While the pediatrician and myself had discussed the operation of the children's clinic in detail and while we had talked casually of the out-patient department to the other staff men, they had not taken very much interest in the matter, feeling that it was a nice thing to consider theoretically, but they never seriously considered the starting of such service. However, every one of them came out of that out-patient department smiling happily, shaking their heads and forming into groups to discuss this wonderful miracle which had grown up overnight, its value and its success. Then they came around hunting for the superintendent, demanding that various other clinics be started at once, for all the various services. To each we stated that as soon as the need was demonstrated, we would furnish a schedule, but that they were in a far better position to determine this need than the hospital. A special meeting of the staff was called, which was fully attended, and the need of a complete out-patient department was thoroughly discussed. Every man told of the things he knew which demonstrated the need of such a service, and it was unanimously agreed that we should inaugurate such

a service as soon as it could be arranged. A committee was appointed to confer with and assist the superintendent. The next morning was the second of our children's clinics, and twenty-one new cases were in attendance. And in addition, six returned from the week previous. We had a regular overflow meeting, our dietitian taking care of the feeding and undernourished cases and receiving advice from the attending physician, who, with his assistant, was literally swamped in the one small examination room.

One thing we had to do promptly was to set days for such other clinics, as we found cases which needed to be referred to the various services. We arbitrarily did this, telling the mothers to return to the surgical; the ear, nose and throat; the eye; the mental clinics, etc., on the day we then determined upon. After the clinic, the chief came to the superintendent and demanded more examination rooms. He was emphatic in his statement that another examination room must be had, at once. Then we sat down and made up examination cards for each service and assigned our staff to begin the first week in July. We then purchased sufficient beaver board and put in a partition of this material with a door dividing the large waiting room in half and making one portion another examining room.

Papers Give Clinics Publicity

On the following Saturday, the three dailies carried large headline stories about the various clinics, including the time, etc. On Monday, we started with the following schedule: 9 a. m., sick children, and at the same hour, nutrition clinics; 11 a. m., psychopathic; Tuesday, 9 a. m., eye, and at the same hour, prenatal clinics; Wednesday, 9 a. m., medical; Thursday, 9 a. m., ear, nose and throat; Friday, 9 a. m., surgical; Tuesday evening, 7 p. m., venereal.

Our staff was organized so that each man had his part. Where there were two men on a service, one was assigned out-patient department and one house for six months and then switched for the following six months.

The three local welfare organizations have cooperated splendidly. The Public Welfare Association investigates every case, as to its social condition. The visiting nurses and the Red Cross refer many cases. The visiting nurses also take one of our pupils into the follow-up service. Our laboratory and drug room are at the disposal of the clinics at all times. Minimum charges are made whenever possible.

While it has been our endeavor to make it clear that only the very poor are to receive the benefits of the out-patient department, there have, of course, been a number of cases attending the various clinics who were financially able to pay their family physician for examination and treatment. Sometimes this can be noted from the general dress and appearance of the patient or the relatives accompanying the patient, and sometimes the information is given quite frankly to the admitting clerk (and in these cases it is simply a misunderstanding on the part of the prospective patient as to what the department has been established for). In our community, as in most others, there is a lack of understanding, sympathy, or cooperation among various groups of practitioners, and those men, connected with other hospitals, deeply resented the fact that some of their patients were coming to our out-patient department and receiving advice and, where needed, treatment. We have tried to minimize these cases as follows: when the patients enter they are asked the following questions: name of father, name of mother, by whom employed, income, number in family, number of

sick members of the family, and name of family physician. If this information indicates that the family may be in a position to pay for their services, a few words of advice regarding the patient is given and he is then referred back to his family physician with a note from the attending clinical man as to what he may have discovered or may have said.

All other cases are given a thorough examination, treatments are ordered and the patient is asked to return on the next clinic day. If it is a first visit, the name, address, and information given are transcribed on a sheet which includes numerous other questions dealing with the social or financial condition of the family, and these are sent to the local public welfare organization, who make the entire investigation for the hospital and send the reports back in order that we may have them at the next visit of the patient, or that we may know what course to pursue if the patient has had to come into the hospital immediately. In this manner we are minimizing the amount of care given to people in a position to pay and it has done much to eliminate the criticism from the family physicians or from other groups of men. That too much consideration should not be given to these criticisms is evidenced by the fact (and it has been our pleasure to point out to some of our critics specific cases) that patients come to us who have been under the care of some other physician at some previous time and we find the patient in a serious condition or needing immediate medical relief so that we are able to say, "If this is the kind of service you have been giving your patient you ought not to say very much about it because it reflects upon your practice of medicine."

In the follow-up of these cases we are using one of our pupil nurses in conjunction with the Visiting Nurses' Association.

Have Not Started Pay Clinics

We have not attempted to form any pay clinics, nor do I think we will for the present. We are keeping very clearly in mind the fact that in a small community such as ours, new ventures like this are largely educational, and that, if they are to ever grow into the big things they ought to be they must develop slowly. Also in order to secure the best results the demand for improvement in the operation of the idea must come from the outside. In this connection, I wish to emphasize the fact that we all in our hospital realize that there are many imperfections in the way in which we are operating this department and that there are many improvements to be made. We realize that the waiting room is very imperfect, that the examination rooms are not equipped as they should be, that they are crowded, that there should be pay clinics, that there should be better follow-up service, that the work might be more thoroughly done, but I am strongly of the opinion that no person or group of persons can get the vision of a big idea, a big plan, or a big development and sit down and plan the operation of this idea or development in detail, then put in all the machinery, start it off, and have it work out as planned. But I do believe most thoroughly that we ought to take our idea or our development plan, put it into operation as quickly and as well as possible, and then iron out the wrinkles afterward, and improve it as we go along. I believe that the service this little out-patient department has rendered the community during its three months of operation, the good it has accomplished, and I might add the lives that have been saved, fully justifies its existence and far outweighs its many small imperfections.

It may be of interest to you to know that in addition

to the people from the city who have attended the clinics, we have had a considerable number of patients from the rural communities; farmers and residents from small towns are coming in here or being brought here by the rural physicians.

So Far Little or No Expense Incurred

You will observe that there has been little or no expense attached to our out-patient department thus far, but with the continued growth of the work the matter of financing it must be given consideration. As we develop our other hospital facilities, it will be necessary to use the present rooms for other purposes and in doing that we find ourselves in the fortunate position of having a building on the grounds facing a side street, in which are housed our maids and porters. The ground floor of this building could be made into a really first class out-patient department, but when this is done there will be additional costs in higher wages to the help and in maintaining the building. And in addition to this, as our hospital fills up with patients, there will be the additional cost in maintaining the increased amount of charity work which is now taken care of with our present overhead, with no additional expense. The method we are most seriously considering is that of either going before the public with a statement of exactly what our free children's department and our out-patient department are costing us, and asking for contributions to support this work, or on the other hand putting this part of our hospital service into the federated charities. We feel that support of such special work will be far more generous and spontaneous than if we should ask the public to support the hospital as a whole.

NATIONAL BOARD PLANS TO GIVE CERTIFICATE BY EXAMINATION

The National Board of Medical Examiners has just completed its first five years' work and with it the trial period of its usefulness. The principle which this board has stood for, namely, the establishment of a thorough test of fitness to practice medicine which might safely be accepted throughout this country and abroad, has been widely accepted. Since the board was organized by Dr. W. L. Rodman, in 1915, eleven examinations have been held. These examinations have been conducted on the plan of holding at one sitting, a written, practical and clinical test for candidates with certain qualifications, namely a four-year high school course, two years of college work, including one year of physics, chemistry, and biology, graduation from a Class A medical school, and one year's internship in an acceptable hospital. These examinations have covered all the subjects of the medical school curriculum and have been conducted by members of the board, with members of the profession resident in the place of examination appointed to help them. Such examinations have been held in Washington, Philadelphia, New York City, Boston, Chicago, St. Louis, Rochester (Minn.) and Minneapolis. During the war a combined examination was held at Fort Oglethorpe and Fort Riley. There have been 325 candidates examined, of whom 269 have passed and been granted certificates.

Starting with the endorsement of the Council on Medical Education of the American Medical Association, American Medical College Association, and various sectional medical societies, the recognition of the Army, Navy, and Public Health Service Medical Corps of the United States, and certain state boards of medical examiners, the certificate is now recognized. Also by twenty states, as follows: Alabama, Arizona, Colorado, Dela-

ware, Florida, Georgia, Idaho, Iowa, Kentucky, Maryland, Minnesota, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Pennsylvania, Rhode Island, Vermont and Virginia, the Conjoint Board of England, the Triple Qualification Board of Scotland, the American College of Surgeons and the Mayo Foundation of the University of Minnesota.

Widespread Demand for Examination

There has been such a widespread demand for an opportunity to secure this certificate by examination, that the board has now adopted and will put into effect at once, the following plan: Part I, to consist of a written examination in the six fundamental medical sciences: anatomy, including histology and embryology; physiology; physiological chemistry; general pathology; bacteriology; materia medica and pharmacology. Part II, to consist of a written examination in the four following subjects: medicine, including pediatrics, neuropsychiatry, and therapeutics; surgery, including applied anatomy, surgical pathology and surgical specialties; obstetrics and gynecology; public health, including hygiene and medical jurisprudence. Part III, to consist of a practical examination in each of the following subjects: clinical medicine, including medical pathology, applied physiology, clinical chemistry, clinical microscopy and dermatology; clinical surgery, including applied anatomy, surgical pathology, operative surgery, and the surgical specialties of the diseases of the eye, ear, nose and throat; obstetrics and gynecology; public health, including sanitary bacteriology and the communicable diseases.

Both Written and Practical Examinations

Parts I and II will be conducted as written examinations in Class A medical schools, and Part III will be entirely practical and clinical. In order to facilitate the carrying out of Part III, subsidiary boards will be appointed in the following cities: Boston, New York, Philadelphia, Minneapolis, Iowa City, San Francisco, Denver, New Orleans, Baltimore, Galveston, Cleveland, St. Louis, Chicago, Washington, D. C., and Nashville, and these boards will function under the direction of the national board. The fee of \$25.00 for the first part, \$25.00 for the second part, and \$50.00 for the third part will be charged. In order to help the board, the Carnegie Foundation has appropriated \$100,000 over a period of five years.

At the annual meeting held June 13 of this year, in Boston, the following officers were elected: M. W. Ireland, Surgeon General, president; J. S. Rodman, M.D., secretary-treasurer; E. S. Elwood, managing director.

Mr. Elwood will personally visit all Class A schools during the college year to further explain the examination, etc., to those interested. Further information may be had from the Secretary-Treasurer, Medical Arts Building, Philadelphia.

PATIENTS FOLLOW WORLD SERIES

The patients of Roosevelt Hospital, New York City, were well informed of the progress of the recent world series games between the Giants and Yankees by a novel method. The bell system used to summon doctors and nurses from one part of the hospital to another was utilized for inning-by-inning reports. George W. Stock, superintendent of the hospital, devised the code, which was explained to the patients beforehand. To those patients especially interested in the series, more detailed reports were given by the nurses. Two hundred keenly interested fans followed the game in this manner.

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OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, National Society for the Promotion of Occupational Therapy, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY AT KENILWORTH HOSPITAL*

BY BERTHA THOMPSON, HEAD RE-AIDE, UNITED STATES PUBLIC HEALTH SERVICE HOSPITAL No. 45, BILTMORE, N. C.

THE hospital with which I am connected, the United States Public Health Service Hospital in Biltmore, N. C., is not a very large one. We have had between 250 and 300 patients most of the time since it opened last November. Many of our patients come in for examination only, and remain at most for a week or two. Others stay several months. We have three surgical wards, five wards for general medical cases, two of which are for colored patients, and two wards for tuberculosis. Some mental cases come in, but these are eventually transferred for treatment to other hospitals.

The hospital building is the large hotel known as Kenilworth Inn, which has been rented by the government. It was used as a military hospital for a year and a half. It is beautifully situated on a hill overlooking the well known Vanderbilt estate. Some ten or twelve private houses nearby have been rented for the doctors and their families, and for nurses' and aides' quarters. There is also a recreation house on the grounds, built by the Young Men's Christian Association while Kenilworth was an army hospital, and we have our workrooms at present in this attractive building.

The first space assigned to me for the work was a corner of the large ballroom in the main building. This room was used for recreational purposes also. We carried on our work there under great difficulties for five months, until the coming of warm weather made it possible to take possession of a group of rooms in the recreation house, consisting of an office, a room for basketry and weaving, another for leather work and bookbinding, a good sized storeroom, and two very small rooms, one of which is used for painting and staining, but will later be equipped for dyeing. None of these rooms are large, but they have served very well so far. In the main building we have

a wood shop, and a room where we keep supplies for the ward work.

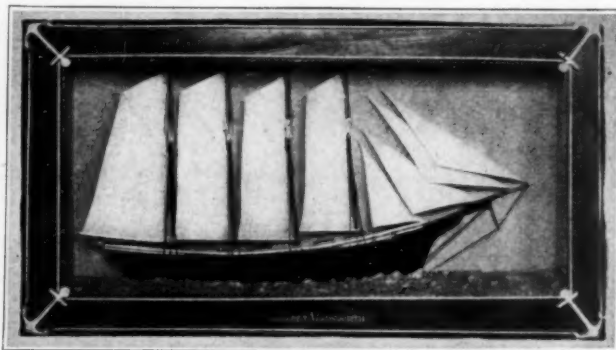
All but a small proportion of the supplies used previous to August first, were purchased by the Red Cross. It is due to the very generous support of this organization that we were able to accomplish so much in the first seven months of our work. As nearly as I could estimate from the incomplete records available, between the middle of December and the first of August about \$150 was spent for tools and equipment, and \$1,400 for materials. We have returned to the Red Cross \$575 received from the patients for materials they have used and paid for. We still have some Red Cross supplies on hand, but since

August first considerable government material has come through to us.

This brief survey will give you some idea of the size of our department.

The Bureau of Public Health Service was asked to undertake an almost overwhelming task when called upon to provide for the hospital care and treatment of the War Risk Insurance patients. And as far as occupational therapy was concerned, it soon became apparent to me that there would be considerable

delay in making adequate provision for necessary supplies and equipment. Therefore, wishing to make the Red Cross funds go as far as possible in buying materials, I decided to begin with a few of the crafts that required the least expensive tools and equipment, leaving such others as jewelry, metal work, carpentry, large loom weaving, etc., to be provided for by the Public Health Bureau as soon as possible. The result has been that up to this time our work has been confined to basketry, leather work, modeling, toy making, bead work, knitting, crocheting, knotted string work, some simple weaving on bedside looms, and such bookbinding as could be done without much equipment. A wood shop was soon needed in order to have some place in which to make bead looms, frames for weaving,



1. Schooner model in high relief. One of many made from scraps of old lumber by a tuberculous patient at Kenilworth Hospital, U.S.P.H.S. Such good work as this should command a fair price and might easily become a vocation as ship models are very much in demand.

*Read at the September, 1920, meeting of the National Society for the Promotion of Occupational Therapy.

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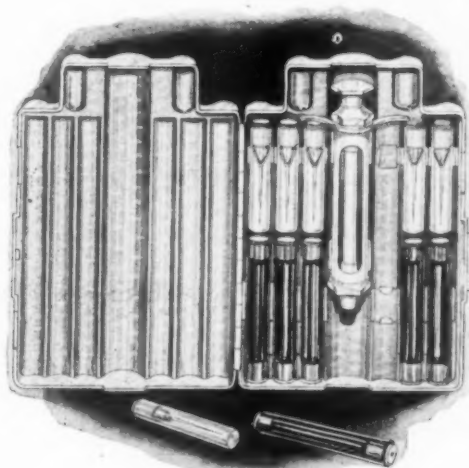


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etc., so I bought a few carpenter's tools, trusting that the Bureau would complete the equipment later. In spite of the limited supply of lumber we could obtain, and the few tools available, the patients have done some good work in the shop. In addition to bead looms and frames for weaving, they have made toys, bird houses, cribbage boards, book ends, walking sticks, kites, flower boxes for the hospital, and cases for writing paper. Any number of frames for reed lamps, and wooden bases for trays, have been prepared in the shop.

Basketry Most Popular

I was able to bring only a small exhibit of the work of our patients, but it is fairly representative, except that I should like to have included one or two of the many attractive reed lamps they have made. Basketry, of course, has been the most popular craft. In eight months we have used about 300 pounds of reed, which will give you an idea of the large number of baskets, trays, and lamps that have been made. Leather work has interested another group of patients. It is the useful article that appeals to them, bill folds, cases to hold their papers of honorable discharge from the army, covers for their pocket kodaks, purses and bags to give to their friends, and so on. These have been in both cut and tooled leather. The toy village was made by a young soldier from the Canadian army.

In the wards we have done a great deal of bead work, using both glass and steel beads. We have made numberless chains of sealing wax, and some of permodella, decorated with water colors. For a few weeks the making of sport hats was popular. We used canvas shapes, working them with raffia, or embroidered straw hats with wool. The basketry has been done both in the wards and in the workroom. I have used Dr. Hall's rough hewn toys for some of our bed patients and have found them helpful.

Should Not Encourage "Fads"

Most of you probably visited one at least of the military hospitals and may have seen that gaily colored thing called a "pillow top," an article distantly related to the simple white cotton Colonial mat. The making of these pillow tops spread like an epidemic through the military hospitals. The patients spent any amount of money on materials, and many people paid exorbitant prices for them. From my point of view, they are dreadful things, useless, ugly, and a waste of good materials. If we are to sanction this kind of hospital product in the name of occupational therapy, we had better stop to consider seriously what we are doing. The process used in making these pillow tops is not a bad one, although the use to which it has been put is unfortunate. It is simple, easy to do, and appeals to many. In an effort to win the boys from this craze, I have encouraged the making of wool shawls and baby carriage covers. Although shawls made in this way are not as good as if knitted or crocheted, they are at least quite serviceable. Knitting is a slower process, and few of the men who have made these knotted shawls could be persuaded to knit. But I was filled with grave doubt the other day when I went in to see one of our patients, who had been making a lot of shawls. I had not realized how many, as he had supplied his own materials. He said, "I have made over a hundred, I have them on sale in six cities, I get from ten to fifteen dollars for them." He had two patients assisting him, and a third to whom he was "teaching the trade." O, thought I, have I started an industry perhaps almost as undesirable as the craze for pillow tops involving, maybe,

a doubtful use of good materials? I leave you to examine the shawls in the exhibit and to judge for yourselves.

We have been struggling with certain problems in connection with our occupational work which are probably not peculiar to a Public Health hospital, and are therefore worth calling to your attention. One of the most important of these problems, from the point of view of the patient, has been the difficulty in arousing sufficient interest among the physicians to persuade them to put the work on a prescription basis, and to give it the careful medical supervision it should have. We have been left to work with any patients we could interest, without knowing very much about their physical and mental condition. The absence of medical supervision in the case of our tuberculous patients has caused me special concern. They are usually most eager to work, and of course should be carefully watched.

We have failed to reach patients who will work only on a doctor's order. On the other hand, in our type of hospital, there are many coming in for examination only, who cannot be regarded as sick men, or in need of a diversional or curative occupation. Still others are well enough to take advantage of the classes of the Vocational Bureau. In the absence of prescriptions we have had no way of knowing which these patients were, nor have we had any authority to refuse them work, so that much time and materials have been expended upon them that should have been saved for those who really need our help. I am glad to say that three weeks ago our medical officer in charge issued orders to the physicians, placing occupational therapy upon a prescription basis. It is too early to report on the results, there will naturally be a few weeks of difficult transition, but I hope it will be successfully carried out, and will put our work on a sounder basis. I sometimes question the wisdom of introducing occupational therapy into any hospital unless it is given medical supervision from the very beginning.

Ask Patients to Make Certain Things

Prescriptions will also help to emphasize the therapeutic purpose of occupation, and assist us in eliminating certain undesirable practices which have developed in some hospitals. Among these I want to mention one, which from the point of view of the welfare of the patients I consider serious, and which should be checked before it becomes a custom. Some physicians, nurses, and other employees have formed the habit of asking the patients to make things for them. It is not always desirable from a therapeutic standpoint to allow the patients to do this work, especially if it means making the same articles over and over again. In an effort to check this I have asked that all such requests should first receive the approval of the director of occupation. Like many other regulations in the interest of the service, however, we have found this difficult to enforce. Not until the physicians come to regard occupational therapy as a purely medical service, to be governed by prescription, shall we succeed in establishing the right attitude toward the work among both the patients and the personnel.

This naturally leads to the question of the disposal of the products of hospital occupations. In the Public Health Service we have fallen heir to many customs that prevailed in army hospitals during the war. Little attempt was made to control the sale of the products of occupational therapy. The sentimental public often paid really ridiculous prices for things made by the soldiers, quite regardless of the quality of workmanship, or the intrinsic value of the articles. The result is that many of our



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Public Health patients have an exaggerated idea of the money value of the things they make. Hospital products should be sold through authorized channels only, and at reasonable prices, on the basis of the quality of the work. They should be sold strictly on their merits, and a standard maintained comparable with that of similar handwork done outside. Anything falling below this standard should not be sold. This should be true whether the article is sold for the benefit of the individual patient, or to secure funds for maintaining the service. The question has arisen as to whether the control over articles made from materials bought by the hospital can be extended to cover also those made from materials supplied by the patients themselves. It would seem advisable that the same regulations should govern the sale of all work in hospitals, regardless of the source of materials.

The need of improving the quality of hospital products, and the means we might employ to this end; the value of good design and workmanship; the grade of tools and materials provided; the need of more suitable workrooms and workshops in many hospitals; the problems involved in the financial aspects of the work; these are all subjects of vital interest to us. But perhaps most important at the present time is the question of the qualifications that should be required of teachers of curative occupations. May I say just a few words in regard to this.

Skilled Worker Appreciated

It has been my experience that the service of the poorly qualified reconstruction aide is not satisfactory from any point of view. The sick appreciate the skilled worker and the good teacher as quickly as any one. You cannot appeal to grown men and women, in possession of their normal mental faculties, with trivial things, or by kindergarten methods. If you want to win their interest you must offer them something worth doing, and provide teachers who know the technic of the crafts they teach, and are also tactful, sympathetic, alert, and thoroughly interested in their work. Technical knowledge should be so well grounded that a teacher can give her undivided attention to her patient, and to the effect of the work upon him. If she is instructing in basketry and must stop to puzzle over the next step in weaving a border, or how to put on a handle, she will in all probability lose the interest of her patient and find it difficult to keep him at work.

We cannot of course expect occupational teachers to be experts in all the crafts that may be taught in a hospital, but it seems quite reasonable to require that they should have thorough knowledge of at least one or two, and sufficient experience of most of the simple forms of handwork to enable them to acquire further technical points as rapidly as they need them.

Sometimes Has Not Right Attitude

The inexperienced worker coming into hospital service without any special training in occupational therapy is at a disadvantage in other ways also. Very often she does not know how to deal with sick people, and she sometimes fails to maintain the right professional attitude toward her patients. She is apt to be overwhelmed by conditions she finds. Her ignorance of hospital customs often brings her into conflict with other employees, and places her in a very unhappy position.

In the absence at the present time of a sufficient number of well trained men and women to meet the demand for occupational therapists, there is grave danger of this work falling into the hands of amateurs, and inexperienced workers. I believe this conference can help in some

measure to prevent this by adopting at least a minimum standard of education, special training, and experience that should be required of all occupational teachers.

THE WATCHED POT

Medical men are getting hold of occupational therapy at the two ends and working up toward the middle. Perhaps the majority of us look upon it as diversional and are content with that. There are other men who see only the mechanical or orthopedic possibilities. Those of us who are devoted to occupational therapy in its comprehensive sense are not troubled by what seems to us partial or restricted views. We know that time will demonstrate the larger values to those who will use the principle at all.

Dr. John H. Arnett, in the July number of the *American Journal of the Medical Sciences*, says, "instead of looking upon it as a means of amusing and diverting the patient, a study was made to determine just which muscles and joints were brought into play by each occupation."

Occupational teachers should, as far as possible, get specific instructions from the doctors in charge of their cases. We may do harm by over-stretching atrophied muscles and tendons, and it is possible to fail of specific accomplishment by neglecting to use effectively the muscle groups that are most in need of development. Excellent results may follow the daily use of a screw driver as a wrist exerciser, but we must remember that any occupation, which has for its sole purpose the exercise of a single muscle or joint, may prove disheartening in results because the patient consciously, or unconsciously, resists the motion that hurts, or is difficult, and that the chances are many to one that the occupation devised for the benefit of a muscle group will not be interesting. If the work is not interesting there will be no enthusiasm and we shall miss the development of morals, without which occupational therapy loses much of its medical value.

In the pursuit of a desirable and specific end, we shall do well to remember the principle of indirection. Give the patient some really interesting work which is within his strength and which involves the use of many muscle groups, and he will invariably use the affected group also. Moreover, being off his guard, he is likely to use that group to much better advantage.

Dr. Arnett, in the article mentioned above, speaks of the value of recording instruments and of a system of records which plots out and makes a graph of improvement. He says truly enough that the patient will be interested in these measurements and will work hard for a good showing. My own experience would prompt me to use such instruments of precision very rarely, or at long intervals, and when there would be evidence of very considerable gain, on the principle that the daily watching of slow improvement is likely to be discouraging to the patient. "The watched pot never boils."

ERROR CORRECTED

Our attention has been called to an error in the name of one of the doctors mentioned in the article, in our August issue, on "West Baden as a War Emergency Hospital." The last line on page 122 and the first two lines on page 123 should read "Captain Charles S. Rebeck of Harrisburg, Pa., a graduate of the College of Physicians and Surgeons (University of Maryland), Baltimore, Md., treated diseases of the ear and throat."



Another Mystery Cake

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HOW TO MAKE IT

Use level measurements for all materials

½ cup shortening	4 teaspoons Royal Baking Powder
1½ cups sugar	1 cup milk
Grated rind of ½ orange	1½ squares (1½ ozs.) of unsweetened chocolate (melted)
1 egg and 1 yolk	¼ teaspoon salt
2½ cups flour	

Cream shortening. Add sugar and grated orange rind. Add beaten egg yolks. Sift together flour, salt and Royal Baking Powder and add alternately with the milk; lastly fold in one beaten egg white. Divide batter into two parts. To one part add the chocolate. Put by tablespoonfuls, alternating dark and light batter, into three greased layer cake pans. Bake in moderate oven 20 minutes.

FILLING AND ICING

3 tablespoons melted butter	1 egg white
3 cups confectioner's sugar	3 squares (3 ozs.) unsweetened chocolate
2 tablespoons orange juice	
Grated rind of ½ orange and pulp of 1 orange	

Put butter, sugar, orange juice and rind into bowl. Cut pulp from orange, removing skin and seeds, and add. Beat all together until smooth. Fold in beaten egg white. Spread this icing on layer used for top of cake. While icing is soft, sprinkle with unsweetened chocolate shaved in fine pieces with sharp knife (use ½ square). To remaining icing add 2½ squares unsweetened chocolate which has been melted. Spread this thickly between layers and on sides of cake.



ASSOCIATED RECONSTRUCTIONISTS

By MARY J. J. WRINN, EDITOR, THE RE-AIDE'S POST, NEW YORK CITY

THE activities of reconstruction aides during the World War have stimulated the development of three national societies: the National Society for the Promotion of Occupational Therapy, the American Women's Physical Therapeutic Association, and the National Association of Ex-Military Reconstruction Aides. The three societies have distinct though related purposes.

Both occupational therapy and physiotherapy had been employed to some extent for years before the war. But the principles underlying their use were not generally known. The World War brought them to the light, and the "fads" proved their own effectiveness.

In order not to lose the ground that occupational therapy was fast gaining during the early months of the war, a group of enthusiasts, calling themselves the National Society for the Promotion of Occupational Therapy, banded together. Since that date in 1917, the society has developed into a well organized body, the influence of which is far-reaching.

Members of the society are divided into four types: active—persons in any way engaged in occupational therapy; associate—those who, seeing the importance of the idea, want to contribute to its development; sustaining; and honorary members. The object is to assist in the establishment of occupational systems in hospitals and sanatoriums, and to coordinate the activities of all charitable organizations using or directing the work.

State O. T. Societies Connected with National

The National Occupational Therapy Society is the fountainhead of state occupational therapy societies in the District of Columbia, New York, Illinois, Wisconsin, Missouri, Maryland, Massachusetts, and Michigan. The aims of the society have been realized to the extent that the word "promotion" is no longer felt necessary as a component part of its name, and a change is being considered.

Officers of the N. S. P. O. T. are: Dr. Herbert J. Hall, president; Dr. Floyd Haviland, vice-president; Miss Marion R. Taber, treasurer; Mr. Louis J. Haas, secretary. Mrs. Eleanor Clarke Slagle, Mrs. Carl Henry Davis, Miss Susan E. Tracy, R.N., Mr. Thomas B. Kidner, and Dr. W. R. Dunton, Jr., act as a board of management. The occupational therapy department of THE MODERN HOSPITAL serves the purpose of an official journal.

To meet the needs in the physiotherapy field in somewhat the same way that the N. S. P. O. T. has met them in the occupational field, the American Women's Physical Therapeutic Association was formed last March. It is the youngest of the national societies. It is the outgrowth of an association formed at Walter Reed Hospital, Washington, D. C., early in 1920.

Three classes of members are admitted to the society: charter members—reconstruction aides in physiotherapy with a total of one year's training and experience in the Army or the Navy of the United States or its Allies, provided that such reconstruction aides apply for membership by next March; active members—graduates of recognized schools of physiotherapy or physical education who have had training and experience in electrotherapy and hydrotherapy; honorary members—graduates of medical schools conforming to the standards of the American Medical Association. The objects of the association are

to advance physiotherapy as a profession, to standardize the work, to disseminate medical literature of professional interest to its members, to secure positions for its members, and to sustain social fellowship and intercourse upon grounds of mutual interest. With these ends in view, the *P. T. Review* made its first appearance last month as the official journal of the organization.

Officers of the A. W. P. T. A. are: Miss Mary McMillan, president; Miss Beulah Rader, Miss Emma Heilman, vice-presidents; Miss Janet B. Merrill, treasurer. Miss Hazel Furchgott and Miss Marien Swezey constitute an executive committee. At this writing, the secretary, to be appointed by the executive committee, has not been named.

The Physio Society has local chapters in New York, Boston, Chicago, Los Angeles, San Francisco, the District of Columbia, Portland, Ore., and New Haven, Conn.

Ex-Service Aides Have Society

Many members of both these societies, united by the common bond of service with the colors, are members also of the National Association of Ex-Military Reconstruction Aides. Men and women who served during the World War emergency as occupational or physiotherapy aides in the Medical Department of the United States Army, are qualified for membership in the military society. The aim is a social one—to augment the friendships and interests developed during the period of service. Furthermore, in the event of another emergency, the members, an experienced group, tried out in the fires, stand ready to serve if needed.

This National Association of Ex-Military Reconstruction Aides is the development of the Fort Sheridan Society of Military Aides founded at Lovell Hospital in May, 1920. One of the objects of the Sheridan body was to effect as soon as possible a national association. With the attainment of that purpose, it ceased to act as the Sheridan Society, became in effect the National Military Association, and as such began formally to function on December 13, 1920.

The national society retained the officers, board of directors, and journal of the Sheridan Society. The officers of the present society are: Miss Belva Cuzzort, who suggested the idea of organizing, president; Miss Susanne Gough, vice-president; and Miss M. Estelle Angier, secretary-treasurer. The board of directors, which, in the Sheridan Society, had been the organizing committee and the nominating committee, consists of Miss Margaret McNamara; chairman, Mrs. René W. Pintó, Mrs. Edith A. Ruehl, and the writer, occupational therapy members; and Miss Mabel Magness, Miss Alice Ueland, Miss Zaidee Bonney, and Miss Dora E. Ellis, physiotherapy members.

Through a four-page paper, the *Re-Aides' Post*, a year old next July, the members of the society, scattered in all the states of the Union, in England, France, Canada, and the Canal Zone, are held together. The paper prints articles by leaders in the fields of occupational and physiotherapy, news of association progress, feature stories, gossip; in brief, news of everything and everybody in any way connected with the work of aides. A column, "Echoes of the Ward," is reserved for news of former patients. The little journal takes subscriptions from interested persons outside the association.

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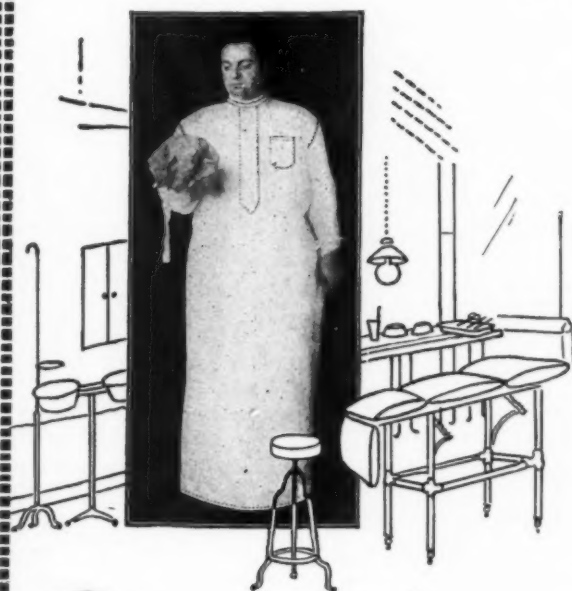
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An activity of the society to which the last *Re-Aides' Post* gave considerable space is the gathering of material for a history of the aides' work in army hospitals. In so far as it has been planned, the history is to be a human interest narrative.

Societies Do Not Overlap

To the casual observer it may appear that three such societies as the N. S. P. O. T., the A. W. P. T. A., and the Military Aides' Society, must encroach on one another's domain and so lessen the influence that might be exerted through union. On the contrary, the strength of the societies is in their very separateness. Each has its special aim which must be furthered through its own sponsors. The societies are not rival teams. There is every reason for sympathy and cooperation. Membership in one seems to imply something like a tacit belief in the high purposes of the others.

Indeed, that belief is not wholly tacit. Many members of the military society, for instance, are members of the N. S. P. O. T. or the A. W. P. T. A., and larger numbers will rally to their support as their existence and aims become known. Membership in more than one of the societies does not mean a duplication of interests. Except for the social clause in the constitution of the physio society, there is no repetition of purposes, and that clause expresses a secondary aim.

The great problem of rehabilitation is the underlying interest of each of the societies, whether formally or informally expressed. For that, will the N. S. P. O. T. strain its energies to the scientific advancement of occupational therapy. And who will question the attitude of the Military Aides' Society toward the great work? Were not all its members of those who actually blazed the trail through difficulty and discouragement? They treasure their tradition. Their pioneer experience demands that they exert an influence for the great cause at issue.

Recruited as they are from many and varied professions, they can exert all the wider influence. Many have it in their power to carry the gospel into communities that still see as boundaries of the curative realm, only the medicine bottle and the surgeon's knife.

In its informal way the Association of Ex-Military Reconstruction Aides may be a powerful force in pushing the work of the other societies and in so doing, lose neither its spirit nor its identity, for rehabilitation is surely an interest which the period of service developed from the very first moment when the aide ventured forth at the challenge: "Enter these enchanted woods, you who dare."

A SUCCESSFUL AUSTRALIAN EXPERIMENT

Of interest to both occupational therapists and governmental departments dealing with the replacement of ex-soldiers is an article in the *American Wool and Cotton Reporter* entitled "Hand Loom Weaving for Returned Soldiers." The article relates the successful experiment on the part of the Repatriation Department of the Australian Government in its factory at Melbourne where ex-soldiers are taught the weaving of tweeds on hand looms. The government experienced such good results from this project that it turned over the factory to the soldiers, themselves, each of whom has an interest in the plant, these holdings being today worth from \$750 to \$1,000. The industry is governed by a trust comprising three directors chosen by the Soldiers' League and is entirely free of official control.

The British Government shortly after the armistice in-

stituted a somewhat similar industry in an effort to aid disabled soldiers and sailors, and it is gratifying to note that cloth merchants as well as cloth consumers are giving every possible encouragement to this commendable enterprise.

"About the same time, our own government gave the matter serious consideration, and went so far as to invite skilled woolen mill workers to qualify as instructors of ex-service men in this particular line of work. Up to date, there appear to have been no further steps taken to advance the project." Surely, it cannot be that the services of war veterans are less appreciated in this country than in any other.

This employment of hand loom weaving is peculiarly adapted to the disabled. Simple but good looking twills in the line of homespun suitings can be made with comparative ease by the worker on a loom of simple type, easily operated, and which does not demand the weaver's constant attention. "He sits on a slanting seat, fixed at the front and center part of the loom, with both legs and feet reaching well down to the treadles; then with the left hand grasping the loom lathe and the right hand the hand pin, he operates the treadles with his feet and the lathe, with shuttles, with his hands, at a speed to suit himself." For those who are further incapacitated by the loss of a leg, provision may be made by means of another type of hand loom which has only a single treadle.

Power Loom Would Not Give Result

In answer to the probable question, "Why not introduce the power loom, thereby increasing production and profit?" it may be said that while commercialism and profit do enter in to a certain extent, these are not the chief aims of the enterprise. The object in view is a vocation that will be health-giving to both body and mind, and this object cannot be realized with the power loom with its "continuous confusing noise from revolving shafting and heavy machinery, together with the necessary active attention to a quick running, somewhat complicated machine." Even to a person of good health, such work is nerve-racking, and its adoption for the handicapped would spell failure.

It is hoped that our own government will not be slow to follow the example of that of the Repatriation Department of the Australian Government, in establishing hand loom weaving for the returned soldiers on a sound industrial basis.

LOVE'S LABOR LOST

During the American Medical Association convention in Boston, doctors from many states visited the occupational therapy shops at Marblehead. The aides on duty enjoyed the task of demonstrating the several departments. One day, two well dressed and alert looking men strolled into the shop and were evidently much interested in the weaving. At the end of a complete inspection, they seemed a little uneasy and finally told the aide that they were steam fitters and had come to repair the boiler.

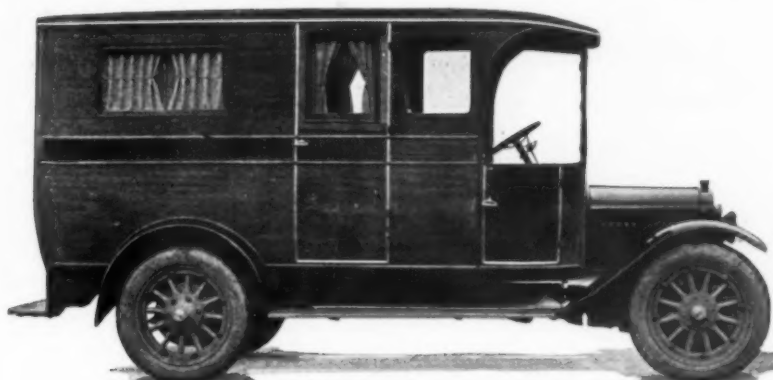
A DEFICIENCY

In a letter to the editors, Mrs. Eleanor Clark Slagle says: "I have yet to find an occupational therapy pupil other than a nurse, who is sufficiently grounded in anatomy and hygiene."

"Nurses are learning that the convalescent period calls for something more than attention to the physical needs."
—Aileen Cleveland Higgins.



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HINTS TO HOSPITAL SUPERINTENDENTS

THINGS YOU CAN HAVE AND DO

WHEN inspiration runs low and we feel ourselves settling into that rut, almost imperceptible—especially to ourselves—the best thing is to go out and see what someone else is doing. And so in imagination come and walk around Wesley Memorial Hospital, Chicago, with its superintendent, Mr. Gilmore, and let him explain to you many clever devices which any hospital may have, because they are the product of ingenuity rather than money. That is the kind that we are looking for today. And more important than devices and explanations let yourself feel the spirit of homelikeness and kindness which pervades the hospital.

Smoking Room On Roof

We go to the top floor of the hospital and work down. On the top floor is a roof garden partly enclosed and partly open to the breeze. In the enclosed part is a small room, a smoking room for the men patients. It is quite a homelike little room and on one side stands a large cabinet filled with curios. Someone "with an understanding heart" as Opal Whiteley would say, placed this interesting collection of things picked up in all parts of the world in the best place to have it enjoyed. An ever changing group of people with plenty of leisure for curios may stand entranced before the glass doors. Why do not more of such things end in hospitals rather than in musty museums where tourists have no time to stop and enjoy them? In another part of the sun parlor and indeed all over the hospital are drinking fountains low enough so that a man in a wheeled chair may comfortably get a drink. In the sun parlor also are two parakeets whose bright coloring is a joy to the eye although their conversation is not particularly musical.

Use Phone Call System

As we descend to the next floor we hear a nasal voice calling someone, and discover that the hospital uses the phone system of calling and has found it very satisfactory. By this means anyone may be called—doctors, interns, nurses, or visitors. Then they step to the nearest phone and take their call. The silent system of lights has been discarded for what the hospital considers a surer system.

We step into an operating room and the first thing that catches our eye is a chamber outside of the skylight. This chamber is about three feet in depth and has steam coils inside it so that the warm air from the room is kept from condensing on the otherwise cold glass and dripping down the window pane. This plan has been adopted by the architects of a number of hospitals. This operating room may be entirely air tight for those physicians who prefer it that way, but for those who wish venti-

lation there is a fan set in a little compartment in the wall which can force air into the room. Sometimes it is possible to please everyone.

Near the operating rooms are two small rooms fitted up as laboratories for the doctors who may wish to do certain laboratory work themselves, or have the interns do it under their direction. These are entirely separate from the main laboratory and Mr. Gilmore has often been assured by his staff that they are the greatest comfort of anything in the hospital.

In a cabinet we find "dressing baskets" of three compartments fitted with everything the doctor will need in making his dressings.

In the corridor stands a Victrola on wheels, and on its rubber tires the Victrola with its records may travel to any part of the hospital.

The nursery has a small dryer which pulls out and then may be pushed back out of the way. In the center of the room is a table, hospital-made, which has a center shelf for supplies and which allows the nurses to work on both sides.

As we walk around we are enchanted by the colors on the walls. They are different shades of yellow, buff and other colors, as the light in the room makes advisable, put on with the "Tiffany finish" which looks like Tiffany glass. As one patient explained, this is so much more interesting than a flat finish for it always looks different. You can see figures in it as you might in the clouds. The hospital can do this because it has its own painters which it keeps busy all the time. Some of the private rooms are finished in a way which any private home might be proud of—white panelled walls with a border of hand painted roses around the top. Across the corner of the rooms is a small closet sufficient for the patient's wardrobe and yet taking up very little space. The lighting in the rooms is indirect with bedside lights. The chairs are very unusual—not institutional at all, just comfortable. Most of them are big leather chairs with wing sides, bought ten years ago, when leather was made to wear long. They more than anything else give the homelike touch to the room. Instead of the bedside table the hospital uses bed top tables which fit over the patient's knees. The radiator has a top built over it making it serve as a table and enhancing its beauty. Every room has a telephone with a private wire.

Wards Have Glass Partitions

Mr. Gilmore has an excellent arrangement in the wards. One end of the large twenty-four bed wards is shut off by a glass partition. Here the patients who like plenty of fresh air and whose conditions call for it may be as cool as they wish without freezing the other patients. Noisy

PROVE

the food and regulatory value of

KELLOGG'S BRAN

cooked and krumbled



Kellogg's BRAN GRIDDLE CAKES

1 cup Kellogg's Bran; 1 cup flour; 1 tablespoon sugar; $\frac{1}{2}$ tablespoon butter substitute; $\frac{1}{2}$ teaspoon salt; 1 teaspoon baking powder; 1 cup milk; 1 egg. Mix dry materials, add egg slightly beaten and milk and butter substitute. Beat thoroughly and bake on a hot griddle. Serve with butter and syrup. This will make 20 cakes.

Kellogg's BRAN BREAD

2 cups Kellogg's Bran; 1 cup boiling water; 1 tablespoon shortening; $\frac{1}{2}$ cup molasses; $1\frac{1}{2}$ teaspoons salt; 1 compressed yeast cake soaked in $\frac{1}{2}$ cup lukewarm water; 4 cups flour. Pour boiling water over Bran. Let stand $\frac{1}{2}$ hour. Add melted shortening, molasses, salt, yeast and flour. Beat well and let rise. Turn into buttered bread pans. Let rise again and bake for one hour.

IN a nation so widely afflicted with constipation personal knowledge of what Kellogg's Bran, cooked and krumbled, can mean to your patients' and to your own health is a matter of utmost importance.

Kellogg's Bran, cooked and krumbled, must not be confused with common or "cooked" bran. Kellogg's Bran is simply delicious in the nut-like flavor of its krumbled, toasted flakes. Yet, it is so rich in vitally needed mineral salts and supplies so much real "roughage"—which stimulates intestinal activity—that it must be regarded as an ideal regulative food. In fact, Kellogg's Bran, eaten regularly, will permanently relieve constipation, naturally! Physicians indorse the use of Kellogg's Bran for constipation.

Eat Kellogg's Bran as a cereal, sprinkled on or mixed with other hot or cold cereals or use it in countless appetizing ways such as in bread, muffins, gems, cookies, drop cakes, etc. Recipes on each package. Kellogg's Bran Griddle Cakes win the fussiest appetite! Oatmeal takes on a new and health-making interest when cooked with Kellogg's Bran. Add $\frac{1}{2}$ cup of Bran to 1 cup of oats and 3 cups of water and cook as usual.

Kellogg's

*Look for
this signature
H.K. Kellogg*

the original BRAN - cooked and krumbled

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patients may be placed here, or patients coming out from under anesthetics. This division makes the ward more quiet and lessens confusion during visiting hours. Mr. Gilmore intends to make a third division in the wards, for it takes no more of a nursing staff as the nurses on duty can look right down through the wards and command the whole room as if the partitions were not there.

Going down to the next floor we walk down the inside fire escape which is occasionally seen in other hospitals. It is made of concrete and marble and has the great advantage of allowing the patients to get down without going outside.

The linen which we pass in large hampers on its way to the proper ward we notice is marked with several figures. These indicate the time it was put out and the floor to which it belongs. This is a check on the floor, to see if it is using its linen carelessly, on the linen, to see if it has the proper wearing qualities, and on the laundry, to see if it is sending back all the linen to the proper floor.

Mother Goose Rhymes On the Wall

In the children's ward we find, besides the elaborate Hallow'en and Thanksgiving decorations, Mother Goose rhymes, with illustrations, decorating the walls. Could anything be more delightful than for children to look up and see, not blank walls, but these ever new and interesting tales to be pondered over and learned by heart? Outside of this ward white gowns are given out to visitors for fear they will carry infection in from the street car or train.

There is a library in the hospital having on one side books of beautiful bindings which belong to the hospital, and on the other side many of the latest books from the Chicago Public Library, of which the hospital is a branch. The Public Library changes the books as often as the hospital wishes. Books are given out to patients here and for those who are not able to come to them the books go out on a little cart.

The hospital has no trouble with having silverware taken off for souvenirs because the nurse is responsible for the set which her patient uses. In ten years no pieces have disappeared.

Next we see a piece of apparatus which is sold by several reliable firms, but which is here made in the hospital. It is a half cylinder of galvanized tin, with from seven to nine sockets for electric bulbs, which fits right over the patient as he lies in bed.

A machine for exercising the muscles of the arm, hand and fingers, which would have cost about \$100.00, was made at very little expense by the engineers of the hospital. It is a wooden table with little things of various weights which may be pushed or pulled. At one end is a roller of graduated sizes which may be turned around. Many patients after they leave the hospital come back to do exercises here.

We have seen many other things from the wonderful electrocardiograph to the diet kitchens—but we are looking for the things today which any hospital might have with the exercise of ingenuity and skill.

Then there is the thing which we have found which any hospital might have with the exercise of great wisdom and patience. That is the spirit of human interest and hospitality. The patient is treated as if he were a guest in a private home. This spirit pervades the whole staff, from the nurse who stops to speak to a patient and perhaps get a glass of water though it is not her patient at all, to the superintendent who devotes an extra three hours a day to making the rounds and calling on every "guest" in the hospital.

HOW TO TEST ENAMELED IRON WARE

Many hospital buyers find extreme difficulty in judging good enamel ware, not only surgical utensils, but also cooking ware and enameled plumbing fixtures.

Although the quality of the ware can be judged somewhat by the appearance; by the absence of roughness, blisters, bubbles, and bare spots; and by gloss, and freedom from hair cracks and peeling, the real resisting quality cannot be readily determined except by use. Enameled ware readily roughened by the application of diluted vinegar should be under suspicion. The question as to whether the enamel sets free such injurious substances as lead and antimony can be determined only by the chemist. The use of either of the above metallic oxids should be prohibited for cooking ware, although allowable in sanitary ware. Care should be taken to prevent contact of acids of all kinds, including vinegar, with enameled surfaces. On no account should bathtubs and basins be cleaned with acids, but soda or alkaline cleaning compounds should invariably be used. A simple test of enameled ware consists in applying either black or red ink to the surface and allowing it to dry. Upon washing it off with clear water no faint stain should be left.

CONSERVATION OF COAL DID NOT END WITH WAR TIME

The Bulletin of the Winnipeg Municipal Hospital gives a timely suggestion concerning the familiar subject of the "Conservation of Coal":

Please bear in mind that every radiator giving off heat which is not necessary for your comfort is a definite and needless waste of coal.

Remember to turn off radiator when you do not need the heat just as you do the electric light when you are not using it.

The cost of running the hospitals is great. Do your part in reducing it by careful observation of the principles of economy in everything you do. It is the little things that count. A penny saved is a penny earned.

UTILIZING OLD BLANKETS AND GAUZE DRESSINGS

Mr. Bacon, of the Presbyterian Hospital, Chicago, made a suggestion at the meeting of the American Hospital Association at West Baden, that is worth passing on. When rubber sheets become old instead of throwing them away, cut them in half, insert a new piece of rubber in the middle and use the old pieces at the sides to tuck under the mattress.

Another superintendent said that in the matter of surgical dressing a substantial saving had been accomplished in his hospital by having the dressing made large at first and then after every washing cutting off the edges which puts them into the next smaller class. This eliminates the frayed edges and greatly lengthens the time which it is possible to use the dressings.

HOSPITAL BOARD TO BE INVESTIGATED

Representative Fitzgerald of Ohio recently introduced a resolution in the House calling for an investigation of the consultant board of physicians appointed by Mr. Mellon, secretary of the treasury, to select sites and make recommendations for the expenditure of \$18,600,000 voted by Congress to provide hospital facilities for ex-service men.



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BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

THE MANAGEMENT OF MEN

A Handbook on the Systematic Development of Morale and the Control of Human Behavior. By Edward L. Munson, Colonel General Staff (Med. Corps); Chief, Morale Branch, War Plans Division. (Lately Brigadier General, General Staff). Prepared with the assistance of Arthur H. Miller, Major, Coast Artillery Corps.¹

"Morale" is a word which has become quite common in newspaper text as well as in conversation since the beginning of the late war. As is the case with so many of our words adopted from the French, the meaning of morale is not always explicit. If the author of "Management of Men" had done nothing more than define the elusive noun "morale" he would merit the thanks of those who use speech to convey thought.

In putting together his material, the author has created a textbook, the first of its kind. It is really a textbook compiled from the results of a great laboratory, for after all, during the war, the army was a great synthetic laboratory, experimenting, analyzing and finally producing as a finished product, the American Soldier. It was the duty of the Morale Branch of the General Staff to collect and utilize the results of the four million experiments resulting from the recruiting and draft campaigns.

This book is not one which can be read; it must be studied and it will repay study. It is a book which can only be absorbed slowly, so crammed are its pages with the concentrated results of wide experience and philosophic deduction.

At the start, reading "Management of Men" is somewhat tiresome due to the author's following the psychological axiom that to tell a man a thing often enough is to have him finally believe it. But after one is fairly into the book, one reads on in spite of himself. While written by an army officer and of necessity focused on the army viewpoint, the worth of Colonel Munson's book is by no means limited to the military minded. The chapter on industrial morale alone should place the volume in the hands of every industrial executive, for, as has been stated above, this book is the first of its kind and the kind that is badly needed, a text of instruction in the art of handling human beings. To emphasize this point, we quote from the author:

The essence of morale work is the development of qualities of leadership. The latter is the ability to handle men so as to achieve the most with the least friction and the greatest cooperation. It seems a curious oversight that with the vast amount of thought, money and material lavished on the military establishment, instruction in the human element which puts them to use, from the efficiency standpoint, has been so completely overlooked. Apparently this essential matter has been left to the individual officer on the wholly unwarranted assumption that example, common sense and experience will tell him the best way to bring his men to greatest efficiency. But

good example is a matter of chance; common sense will not always serve for it must be based on knowledge, while experience often has not been extensive enough to confer such knowledge. The results as to leadership have accordingly been variable. Methods have been more or less unscientific, incomplete and empirical. The degree of success is largely a matter of personal equation. Naturally some succeed, others fail, and probably none do all that might be done under a thorough and clear understanding of the conditions to be remedied and the measures and mechanics of accomplishment.

No amount of technical training or knowledge can make an officer really efficient if he does not possess in addition the power of so controlling his men and of so directing their wills as to preserve harmony in the organization and bring the best out of his men. There are but few right ways of handling men in any emergency, but many wrong ones. The way should be chosen which will give the results desired with the least interference with human instincts and interests. This should not be left either to intuition or chance. Systematic study of human nature makes both unnecessary.

Hospital superintendents will find much of great interest and more of great value in the pages of the "Management of Men" and the section on "The Commanding Officer" (page 308) is especially recommended. As time goes on, there will probably be included in the curriculum of every training school a course in applied psychology. To teachers of such courses the reviewer strongly recommends Colonel Munson's book; he has found it of extreme value in preparing his own lectures on the subject.

As a piece of workmanship, the volume is very well put together in arrangement and binding. It would scarcely be fair to review the book without a word regarding the ingenious diagrams. These charts and drawings, many of them in color, bring out, with remarkable force, the points made by the author.

JOHN F. BRESNAHAN, M.D.

DISEASES OF CHILDREN

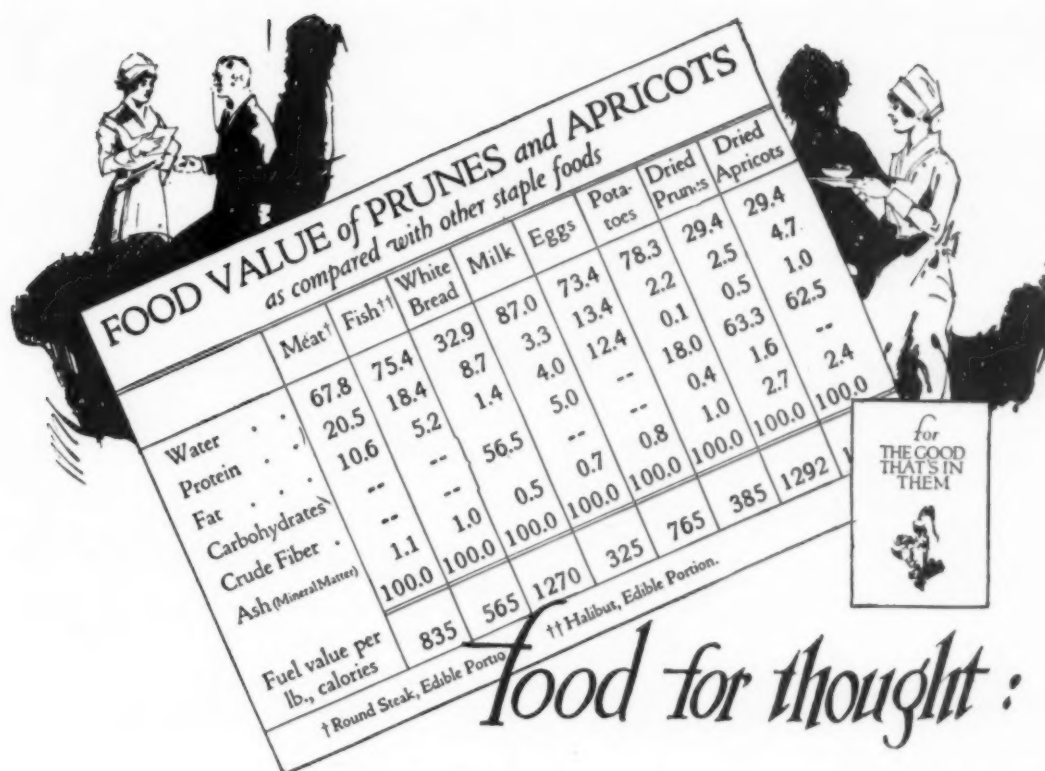
Designed for the Use of Students and Practitioners of Medicine. By Herman B. Sheffield, M.D., formerly Instructor in Diseases of Children, New York Post-Graduate Medical School and Hospital, and Medical Director, Beth David Hospital, Consulting Physician to the Jewish Home for Convalescents and the East Side Clinic for Children.¹

This volume represents an experience in the field of pediatrics of nearly thirty years on the part of the author. Designed especially to meet the needs of the general practitioner and medical student it embodies the latest information both theoretical and practical concerning the diseases of infancy and childhood.

The book is divided into fourteen sections, the classification of the diseases corresponding to the modern conception of the causation of the disease in question. The discussion of infant feeding is based upon the most recent studies of the digestibility of protein, fats and carbo-

1. Henry Holt and Company, New York, 1921.

1. C. V. Mosby, St. Louis, 1921.



FOOD VALUE of PRUNES and APRICOTS
as compared with other staple foods

	Meat†	Fish††	White Bread	Milk	Eggs	Potatoes	Dried Prunes	Dried Apricots
Water	67.8	75.4	32.9	87.0	73.4	78.3	29.4	29.4
Protein	20.5	18.4	8.7	3.3	13.4	2.2	2.5	4.7
Fat	10.6	5.2	1.4	4.0	12.4	0.1	0.5	1.0
Carbohydrates	--	--	--	56.5	--	--	18.0	63.3
Crude Fiber	--	--	1.0	0.5	0.7	0.8	0.4	1.6
Ash (Mineral Matter)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Fuel value per lb., calories	835	565	1270	325	765	385	1292	100.0

† Round Steak, Edible Portion.
†† Halibut, Edible Portion.

Food for thought:

for THE GOOD THAT'S IN THEM

Forget, for the moment, that prunes and apricots can be prepared in so many ways to entice the most palate-weary patient. Set aside the importance of prunes as a laxative from Nature's own pharmacy. But consider this:

Nutrition investigators generally agree that the *carbohydrates* of our food [and not the nitrogenous compounds] are the source of muscular energy for the body. Run your finger along the carbohydrate line in the table at the top. Prunes and apricots "stack up" pretty high—don't they?

Consider now the *mineral* matter in dried fruits. Prunes especially are high in iron. Also they contain certain salts and organic acids which improve the quality of the blood and react favorably on the secretions.

And now—consider this: the experiments of Osborne and Mendel prove that deciduous fruits furnish water-soluble vitamin; and that prunes apparently are richer in this dietary essential than apples and pears.

Food for thought? Well, rather!

Every physician, dietitian and nurse will find plenty of "dietetic meat" in our health-brochure, "For the good that's in them." Sent free! And, if you ask for it, we'll send along an advance copy of the 1922 Sunsweet Recipe Packet. California Prune and Apricot Growers, Inc., 1194 Market St., San Jose, California / 11,000 growers.

SUNSWEEET

CALIFORNIA'S NATURE-FLAVORED PRUNES & APRICOTS

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hydrates and upon the author's experience. The chapter on examination of the patient is designed to aid the beginner in surmounting the difficulties in the diagnosis of infants and older children. A careful survey is presented of the most modern methods of laboratory diagnosis. The diseases of the newborn which cause such a great loss of life are gone into minutely, especially those of a septic nature. The section on respiratory diseases includes those of the nose, throat and ears. The subject of the ductless glands is treated broadly, laying stress on the diseases of the thyroid, thymus, and pituitary glands. The important subject of the communicable diseases of childhood is treated exhaustively. Syphilis and tuberculosis both receive considerable attention.

HANDBOOK OF SOCIAL RESOURCES OF THE UNITED STATES

By Genevieve Poyner Hendricks, The American Red Cross, Washington, D. C.¹

The peace time activities of the Red Cross have brought need for information regarding the general social resources of the country, not merely in relation to soldiers and sailors as was the handbook prepared during the war. As this former book "The Handbook for Home Service Sections" is still available and kept up to date, the Handbook on Social Resources does not attempt to include information regarding agencies whose sole purpose is to render aid to soldiers and sailors and their dependents. The book does not attempt to cover activities which are purely temporary in character, nor those of a local or regional interest.

The handbook is a digest of social resources of the United States, and an endeavor has been made to include, for each organization, mention of its general program; its specific activities; the annual meeting, and whether it is open to the public; the names and work of special and standing committees and commissions; field work and lecture service, to whom available and on what terms; information service and clearing house work, and how this service may be secured; reference and library facilities; survey and investigational activities.

MATERIA MEDICA AND THERAPEUTICS—A TEXTBOOK FOR NURSES

By Linette A. Parker, B.Sc., R.N.²

The third edition of Miss Parker's *Materia Medica and Therapeutics* has all the good qualities of the former editions plus much new material.

A description of the Centigrade and Fahrenheit thermometers is added to the chapter on solutions. A practical method of calculating doses from hypodermic solutions of given strength is included under Posology. A new chapter has been written on Drugs in Solution, giving in detail the description, method of action, uses and care of the solutions more commonly handled by nurses. The discussion of many of the important drugs, the central stimulants, morphine, pituitary body, ammonium, iron and ergot, has been amplified and largely rewritten. Many of the proprietary remedies described in new and non-official remedies are grouped with the drugs to which they are related, many minor additions and changes have been made to make the book more valuable.

This text, representing as it does the work of a nurse for nurses, is written from the standpoint of a trained teacher and is limited to the important and practical

points which form a foundation for an intelligent handling of drugs, but not for prescribing them.

It is generally agreed among teachers that the habit of using the index of a book is an invaluable one for students to form. The classification of drugs by systems which is a unique feature of this text necessitates the use of the very complete index provided. The increased demand for this book is a gratifying indication of appreciation of the service which Miss Parker rendered in compiling it.

EPITOME OF HYDROTHERAPY

By Simeon Baruch, M.D., LL.D., Consulting Physician to Knickerbocker and Montefiore Hospitals. 205 pages.¹

Dr. Simon Baruch of New York City, for a whole generation, has stood as a star advocate of hydrotherapy. His writings, especially his large work on hydrotherapy, have unquestionably been the means of introducing this important branch of therapeutics to a great number of physicians. Dr. Baruch's lucidity of expression, clearness of diction, and accuracy of statements, makes the reading of his books a pleasure. We are glad to note a new book from his pen, "An Epitome of Hydrotherapy." This work, as its title indicates, is an epitome. In two hundred cases the author presents an outline of his views on "the position of water in materia medica, rationale of hydrotherapy, the physical characteristics of water, shock and reaction, the application of water in disease, and the technique of hydrotherapy." Nearly thirty pages are devoted to the question of hydriatic installation, some fifty pages to special procedures adapted to various diseases. The book is well illustrated and will be welcomed by all practitioners who appreciate the value of water as a therapeutic means.

BOOKS RECEIVED

THE PSYCHOLOGY OF NURSING. By Aileen Cleveland Higgins, (Mrs. John Archibald Sinclair, A.B., R.N.) war relief superintendent of the Stanford School for Nurses, San Francisco, California; instructor in War Emergency Courses, University of California. G. P. Putnam's Sons, Pub., New York and London. The Knickerbocker Press, 1921.

MESSAGE AND THERAPEUTIC EXERCISE. By Mary McMillan, assistant at Sir Robert Jones' Clinic, Southern Hospital, Liverpool, England, 1911-1915; in charge of massage and exercise at Greenbank Cripples' Home, Liverpool, England, 1911-1915; supervisor of aides in Physiotherapy Medical Corps, United States Army, Washington, D. C. 1919-1920. Illustrated. W. B. Saunders Company, Philadelphia and London, 1921.

THE ASSESSMENT OF PHYSICAL FITNESS, BY CORRELATION OF VITAL CAPACITY AND CERTAIN MEASUREMENTS OF THE BODY. By Georges Dreyer, C.B.E., M.A., M.D. Fellow of Lincoln College, Professor of Pathology in the University of Oxford, Corresponding Member of the Royal Danish Academy of Letters and Sciences, in collaboration with George Fulford Hanson, Late Lieutenant U. S. A. Medical Corps, Air Service. Foreword by Charles H. Mayo, M. D., Rochester, Minn. Paul B. Hoeber, Pub., 67-69 East 59th Street, New York City, 1921.

NURSES' HANDBOOK OF DRUGS AND SOLUTIONS. By Julia C. Stimson, R.N. Vassar A. B. Washington University, St. Louis, A.M. Graduate of the New York Hospital Training School for Nurses; Superintendent of Army Nurse Corps and Dean of Army School of Nursing United States Army. 3rd ed., Whitcomb & Barrows, Huntington Chambers, Boston, 1920.

THE TECHNIC OF THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY. Preface by J. B. DeLee, M.D. Copyrighted by The Chicago Lying-in Hospital and Dispensary, July, 1921.

1. W. B. Saunders Company, Philadelphia, 1920.

1. The American Red Cross, Washington, D. C.
2. Lea & Febiger, Philadelphia, 1921.



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OBSTETRICS AND GYNECOLOGY UNIT AT ROYAL FREE HOSPITAL

BEFORE entering into a description of the unit of obstetrics and gynecology established recently at the Royal Free Hospital, London, it will be fitting to give a brief account of the history of the hospital in question, which holds a unique position among the hospitals of London, indeed of England. It may be said that since the year 1828, when it was the first of the London hospitals to admit necessitous men, women, and children without the usual formalities, the Royal Free has been a pioneer. In 1877, and this constitutes its chief claim to fame, it led the way in admitting women students to its wards. In 1896 it appointed women graduates as medical and surgical registrars, in 1900 it opened its resident posts to women graduates, and in 1902 it elected two women graduates to its honorary staff. The Royal Free Hospital is essentially the clinical training school for women medical students and is the only hospital in Great Britain devoted to this training. Other hospitals and medical schools admit women students, but only in strictly limited numbers, while many hospitals will not admit them at all. Owing to this fact women students flock to the London School of Medicine for Women and consequently to its hospital the Royal Free. So great has been the increase of students that the clinical facilities of the hospitals have had to be extended. It goes without saying that the efficiency of medical education depends, largely, on the number of cases to be studied, the number of cases depends on the number of beds to receive them. This being so, in 1915 a fund was started to extend the hospital, on land presented by its chairman. Donations, subscriptions and promises have reached £32,000 (\$160,000); and though the school and hospital require a total of £500,000 (\$2,500,000) to carry out the scheme in entirety, the work of extension has materialized so far, that a "unit" of obstetrics and gynecology has been created and 100 additional beds have been equipped for that new and hitherto somewhat neglected class of patients who do not feel themselves justified in accepting free hospital treatment, but who have no facilities for operations in their own homes, and are unable to pay the high fees of a good nursing home. The work in medicine and surgery has become more and more specialized and it was felt that the old methods of teaching by the physicians and surgeons on the staffs of general hospitals was becoming out of date, as a matter of fact, it was found that teaching in this way was not thorough. In 1913 the idea of "units" for the teaching of medicine, surgery, obstetrics, and gynecology was brought forward in the Haldane Commission on University Training, but owing to the war the matter was naturally shelved. The conception of a "unit"

or team-work is that a director and two or more assistants should have under their control a certain number of beds, from sixty to one hundred, and that they should devote all their time to the treatment and care of the patients, the teaching of students, and to research work. The directors are to be chosen on their past record for good work, for their ability to teach, and their interest in and capacity for research. Of course the assistants are chosen for their demonstrated ability, and promise to do still better work. So far only five of the twelve great teaching hospitals of London—St. Bartholomews, The London, University College Hospital, St. Thomas's and the Royal Free—have been recognized by the University Grants Committee as eligible for units. To these directors of units have been appointed by the Senate of the University of London. "Units" for medicine and surgery have been organized in the first four hospitals, while the Royal Free is the first hospital in which a "unit" of obstetrics and gynecology has been established. Formerly the work in general hospitals in connection with obstetrics and gynecology has been under the care of various physicians, obstetricians, and gynecologists. The work at the Royal Free Hospital is now coordinated under the director, Professor Louise McIlroy, and her assistants who will follow the cases from the time they first come under observation.

The unit occupies the top floor of the new wing of the Royal Free Hospital and consists of an obstetrical ward of twelve beds with smaller wards for labor and isolation, etc. Adjoining it are three wards and twenty-six beds for gynecological cases with operating theater, anesthetic and preparation rooms attached. The teaching department, which is at the further end of the wing, consists of a room for examination of patients and demonstrations for students, a professor's room, and assistants' clinical laboratory. Lectures are given to the students in the main lecture room downstairs. There is also a branch connected with the hospital which is under the direction of the "unit" and which contains twenty-six obstetric beds, a few venereal obstetrical cases being included. This hospital was given by the Duchess of Marlborough, nee Vanderbilt, and is situated in convenient proximity to the hospital. It consists of small wards, furnished with taste, and is conducted on the lines of a nursing home. The patients in this department pay for their maintenance in hospital according to accommodation. It has labor wards, isolation, etc. It may be added that the department at the Royal Free Hospital is being equipped for research work upon ante-natal pathology and also upon the physiological processes connected with childbirth and pregnancy. Special researches will be made upon the economic questions in women's work, upon the influence of such on the child, the influence of venereal and other toxic diseases in pregnancy.